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105TH CONGRESS
2D SESSION

H. R. 4250

To provide new patient protections under group health plans.

IN THE HOUSE OF REPRESENTATIVES

JULY 16, 1998

Mr. GINGRICH (for himself, Mr. HASTERT, Mr. ARCHER, Mr. BLILEY, Mr. GOODLING, Mr. BILIRAKIS, Mr. FAWELL, Mr. NORWOOD, Mr. MCCRERY, Mr. HOBSON, Mr. GOSS, Ms. PRYCE of Ohio, Mrs. KELLY, Mr. TALENT, Ms. GRANGER, Mr. CHAMBLISS, Mr. GILCHREST, Mr. WELDON of Florida, Mr. METCALF, Mr. PETERSON of Pennsylvania, Mr. TIAHRT, Mr. BARTLETT of Maryland, Mr. BUNNING, Mrs. NORTHUP, Mr. HUTCHINSON, Mr. GIBBONS, Mr. CHABOT, Mr. BOEHNER, Mr. GREENWOOD, Mrs. FOWLER, Mr. SPENCE, Mr. DUNCAN, Mr. SKEEN, Mr. HERGER, Mrs. CUBIN, Mr. DREIER, Mr. UPTON, Mr. COLLINS, Mr. SESSIONS, Mr. FOLEY, Mr. GILLMOR, Mr. ENGLISH of Pennsylvania, Mr. REDMOND, Mr. ROGERS, Mr. SMITH of Michigan, Mr. MICA, Mr. ADERHOLT, Mr. LATHAM, Mr. FOX of Pennsylvania, Mr. MCKEON, Mr. GALLEGLY, Mr. TAUZIN, Mr. NEY, Mr. HILLEARY, Mr. PAXON, Mr. BALLENGER, Mr. KASICH, and Mr. REGULA) introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committees on Education and the Workforce, Ways and Means, the Judiciary, and Government Reform and Oversight, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To provide new patient protections under group health plans.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE AND TABLE OF CONTENTS.

(a) SHORT TITLE.—The Act may be cited as the ''Patient Protection Act of 1998''.

(b) TABLE OF CONTENTS.—The table of contents is as follows:

TITLE I—AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

Subtitle A—Patient Protections

SEC. 1001. PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE, EMERGENCY MEDICAL CARE, OBSTETRIC AND GYNECOLOGICAL CARE, AND PEDIATRIC CARE.

(a) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended further by adding at the end the following new sections:

"SEC. 713. PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE, EMERGENCY MEDICAL CARE, OBSTETRIC AND GYNECOLOGICAL CARE, PEDIATRIC CARE.

''(a) PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE.—

''(1) IN GENERAL.—In the case of any health care professional acting within the lawful scope of practice in the course of carrying out a contractual employment arrangement or other direct contractual arrangement between such professional and a group health plan or a health insurance issuer offering health insurance coverage in connection with a group

health plan, the plan or issuer with which such contractual employment arrangement or other direct contractual arrangement is maintained by the professional may not impose on such professional under such arrangement any prohibition with respect to advice, provided to a participant or beneficiary under the plan who is a patient, about the health status of the participant or beneficiary or the medical care or treatment for the condition or disease of the participant or beneficiary, regardless of whether benefits for such care or treatment are provided under the plan or health insurance coverage offered in connection with the plan.

''(2) HEALTH CARE PROFESSIONAL DEFINED.—For purposes of this subsection, the term 'health care professional' means a physician (as defined in section 1861(r) of the Social Security Act) or other health care professional if coverage for the professional's services is provided under the group health plan for the services of the professional. Such term includes a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist and therapy assistant, speech–language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner,

clinical nurse specialist, certified registered nurse anesthetist, and certified nurse–midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

"(b) PATIENT ACCESS TO EMERGENCY MEDICAL CARE.—

"(1) IN GENERAL.—To the extent that the group health plan (or health insurance issuer offering health insurance coverage in connection with the plan) provides for any benefits consisting of emergency medical care (as defined in section 503(b)(9)(I)), except for items or services specifically excluded—

"(A) the plan or issuer shall provide benefits, without requiring preauthorization, for appropriate emergency medical screening examinations (within the capability of the emergency facility, including ancillary services routinely available to the emergency facility) to the extent that a prudent layperson, who possesses an average knowledge of health and medicine, would determine such examinations to be necessary in order to determine whether emergency medical care (as so defined) is required, and

"(B) the plan or issuer shall provide benefits for additional emergency medical services following an emergency medical screening examination (if determined necessary under subparagraph (A)) to the extent that a prudent emergency medical professional would determine such additional emergency services to be necessary to avoid the consequences described in section 503(b)(9)(I).

"(2) UNIFORM COST-SHARING REQUIRED.—Nothing in this subsection shall be construed as preventing a group health plan or issuer from imposing any form of cost-sharing applicable to any participant or beneficiary (including coinsurance, copayments, deductibles, and any other charges) in relation to benefits described in paragraph (1), if such form of cost-sharing is uniformly applied under such plan, with respect to similarly situated participants and beneficiaries, to all benefits consisting of emergency medical care (as defined in section 503(b)(9)(I)) provided to such similarly situated participants and beneficiaries under the plan.

"(c) PATIENT ACCESS TO OBSTETRIC AND GYNECOLOGICAL CARE.

''(1) IN GENERAL.—In any case in which a group health plan (or a health insurance issuer offering health insurance coverage in connection with the plan)—

''(A) provides benefits under the terms of the plan consisting of—

''(i) routine gynecological care (such as preventive women's health examinations), or

''(ii) routine obstetric care (such as routine pregnancy-related services),

provided by a participating physician who specializes in such care (or provides benefits consisting of payment for such care), and

''(B) the plan requires or provides for designation by a participant or beneficiary of a participating primary care provider,

if the primary care provider designated by such a participant or beneficiary is not such a physician, then the plan (or issuer) shall meet the requirements of paragraph (2).

''(2) REQUIREMENTS.—A group health plan (or a health insurance issuer offering health insurance coverage in connection with the plan) meets the requirements of this paragraph, in connection with

benefits described in paragraph (1) consisting of care described in clause (i) or (ii) of paragraph (1)(A) (or consisting of payment therefor), if the plan (or issuer)—

"(A) does not require authorization or a referral by the primary care provider in order to obtain such benefits, and

"(B) treats the ordering of other routine care of the same type, by the participating physician providing the care described in clause (i) or (ii) of paragraph (1)(A), as the authorization of the primary care provider with respect to such care.

"(3) CONSTRUCTION.—Nothing in paragraph (2)(B) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of gynecological or obstetric care so ordered.

"(d) PATIENT ACCESS TO PEDIATRIC CARE.—

"(1) IN GENERAL.—In any case in which a group health plan (or a health insurance issuer offering health insurance coverage in connection with the plan) provides benefits consisting of routine pediatric care provided by a participating physician who specializes in pediatrics (or consisting of pay-

ment for such care) and the plan requires or provides for designation by a participant or beneficiary of a participating primary care provider, the plan (or issuer) shall provide that such a participating physician may be designated, if available, by a parent or guardian of any beneficiary under the plan is who under 18 years of age, as the primary care provider with respect to any such benefits.

''(2) CONSTRUCTION.—Nothing in paragraph (1) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of pediatric care.

''(e) TREATMENT OF MULTIPLE COVERAGE OPTIONS.—In the case of a plan providing benefits under two or more coverage options, the requirements of subsections (c) and (d) shall apply separately with respect to each coverage option.''.

(b) CONFORMING AMENDMENT.—The table of contents in section 1 of such Act is amended by adding at the end of the items relating to subpart B of part 7 of subtitle B of title I of such Act the following new item:

''Sec. 713. Patient access to unrestricted medical advice, emergency medical care, obstetric and gynecological care, and pediatric care.''.

SEC. 1002. EFFECTIVE DATE AND RELATED RULES.

(a) IN GENERAL.—The amendments made by this subtitle shall apply with respect to plan years beginning

on or after January 1 of the second calendar year following the date of the enactment of this Act, except that the Secretary of Labor may issue regulations before such date under such amendments. The Secretary shall first issue regulations necessary to carry out the amendments made by this section before the effective date thereof.

(b) LIMITATION ON ENFORCEMENT ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this subtitle, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by such amendments before the date of issuance of regulations issued in connection with such requirement, if the plan or issuer has sought to comply in good faith with such requirement.

(c) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the provisions of subsections (b), (c), and (d) of section 713 of the Employee Retirement Income Security Act of 1974 (as added by this subtitle) shall not apply with respect to plan years beginning before the later of—

(1) the date on which the last of the collective bargaining agreements relating to the plan termi-

nates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

(2) January 1, 2001.

For purposes of this subsection, any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this subtitle shall not be treated as a termination of such collective bargaining agreement.

(d) ASSURING COORDINATION.—The Secretary of Labor, the Secretary of the Treasury, and the Secretary of Health and Human Services shall ensure, through the execution of an interagency memorandum of understanding among such Secretaries, that—

(1) regulations, rulings, and interpretations issued by such Secretaries relating to the same matter over which two or more such Secretaries have responsibility under the provisions of this subtitle, section 2101, and subtitle A of title III (and the amendments made thereby) are administered so as to have the same effect at all times, and

(2) coordination of policies relating to enforcing the same requirements through such Secretaries in order to have a coordinated enforcement strategy

that avoids duplication of enforcement efforts and assigns priorities in enforcement.

(e) TREATMENT OF RELIGIOUS NONMEDICAL PROVIDERS.—

(1) IN GENERAL.—Nothing in this Act (or the amendments made thereby) shall be construed to—

(A) restrict or limit the right of group health plans, and of health insurance issuers offering health insurance coverage in connection with group health plans, to include as providers religious nonmedical providers,

(B) require such plans or issuers to—

(i) utilize medically based eligibility standards or criteria in deciding provider status of religious nonmedical providers,

(ii) use medical professionals or criteria to decide patient access to religious nonmedical providers,

(iii) utilize medical professionals or criteria in making decisions in internal or external appeals from decisions denying or limiting coverage for care by religious nonmedical providers, or

(iv) compel a participant or beneficiary to undergo a medical examination

or test as a condition of receiving health insurance coverage for treatment by a religious nonmedical provider, or

(C) require such plans or issuers to exclude religious nonmedical providers because they do not provide medical or other data otherwise required, if such data is inconsistent with the religious nonmedical treatment or nursing care provided by the provider.

(2) RELIGIOUS NONMEDICAL PROVIDER.—For purposes of this subsection, the term ''religious nonmedical provider'' means a provider who provides no medical care but who provides only religious nonmedical treatment or religious nonmedical nursing care.

Subtitle B—Patient Access to Information

SEC. 1101. PATIENT ACCESS TO INFORMATION REGARDING PLAN COVERAGE, MANAGED CARE PROCEDURES, HEALTH CARE PROVIDERS, AND QUALITY OF MEDICAL CARE.

(a) IN GENERAL.—Part 1 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended—

(1) by redesignating section 111 as section 112; and

(2) by inserting after section 110 the following new section:

''DISCLOSURE BY GROUP HEALTH PLANS

''SEC. 111. (a) DISCLOSURE REQUIREMENT.—

''(1) GROUP HEALTH PLANS.—The administrator of each group health plan shall take such actions as are necessary to ensure that the summary plan description of the plan required under section 102 (or each summary plan description in any case in which different summary plan descriptions are appropriate under part 1 for different options of coverage) contains, among any information otherwise required under this part, the information required under subsections (b), (c), (d), and (e)(2)(A).

''(2) HEALTH INSURANCE ISSUERS.—Each health insurance issuer offering health insurance coverage in connection with a group health plan shall provide the administrator on a timely basis with the information necessary to enable the administrator to comply with the requirements of paragraph (1). To the extent that any such issuer provides on a timely basis to plan participants and beneficiaries information otherwise required under this part to be included in the summary plan de-

scription, the requirements of sections 101(a)(1) and 104(b) shall be deemed satisfied in the case of such plan with respect to such information.

''(b) PLAN BENEFITS.—The information required under subsection (a) includes the following:

''(1) COVERED ITEMS AND SERVICES.—

''(A) CATEGORIZATION OF INCLUDED BENEFITS.—A description of covered benefits, categorized by—

''(i) types of items and services (including any special disease management program), and

''(ii) types of health care professionals providing such items and services.

''(B) EMERGENCY MEDICAL CARE.—A description of the extent to which the plan covers emergency medical care (including the extent to which the plan provides for access to urgent care centers), and any definitions provided under the plan for the relevant plan terminology referring to such care.

''(C) PREVENTATIVE SERVICES.—A description of the extent to which the plan provides benefits for preventative services.

''(D) DRUG FORMULARIES.—A description of the extent to which covered benefits are determined by the use or application of a drug formulary and a summary of the process for determining what is included in such formulary.

''(E) COBRA CONTINUATION COVERAGE.—A description of the benefits available under the plan pursuant to part 6.

''(2) LIMITATIONS, EXCLUSIONS, AND RESTRICTIONS ON COVERED BENEFITS.—

''(A) CATEGORIZATION OF EXCLUDED BENEFITS.—A description of benefits specifically excluded from coverage, categorized by types of items and services.

''(B) UTILIZATION REVIEW AND PREAUTHORIZATION REQUIREMENTS.—Whether coverage for medical care is limited or excluded on the basis of utilization review or preauthorization requirements.

''(C) LIFETIME, ANNUAL, OR OTHER PERIOD LIMITATIONS.—A description of the circumstances under which, and the extent to which, coverage is subject to lifetime, annual, or other period limitations, categorized by types of benefits.

"(D) CUSTODIAL CARE.—A description of the circumstances under which, and the extent to which, the coverage of benefits for custodial care is limited or excluded, and a statement of the definition used by the plan for custodial care.

"(E) EXPERIMENTAL TREATMENTS.—Whether coverage for any medical care is limited or excluded because it constitutes experimental treatment or technology, and any definitions provided under the plan for the relevant plan terminology referring to such limited or excluded care.

"(F) MEDICAL APPROPRIATENESS OR NECESSITY.—Whether coverage for medical care may be limited or excluded by reason of a failure to meet the plan's requirements for medical appropriateness or necessity, and any definitions provided under the plan for the relevant plan terminology referring to such limited or excluded care.

"(G) SECOND OR SUBSEQUENT OPINIONS.—A description of the circumstances under which, and the extent to which, coverage

for second or subsequent opinions is limited or excluded.

''(H) SPECIALTY CARE.—A description of the circumstances under which, and the extent to which, coverage of benefits for specialty care is conditioned on referral from a primary care provider.

''(I) CONTINUITY OF CARE.—A description of the circumstances under which, and the extent to which, coverage of items and services provided by any health care professional is limited or excluded by reason of the departure by the professional from any defined set of providers.

''(J) RESTRICTIONS ON COVERAGE OF EMERGENCY SERVICES.—A description of the circumstances under which, and the extent to which, the plan, in covering emergency medical care furnished to a participant or beneficiary of the plan imposes any financial responsibility described in subsection (c) on participants or beneficiaries or limits or conditions benefits for such care subject to any other term or condition of such plan.

''(c) PARTICIPANT'S FINANCIAL RESPONSIBILITIES.—The information required under subsection (a) includes an explanation of—

''(1) a participant's financial responsibility for payment of premiums, coinsurance, copayments, deductibles, and any other charges, and

''(2) the circumstances under which, and the extent to which, the participant's financial responsibility described in paragraph (1) may vary, including any distinctions based on whether a health care provider from whom covered benefits are obtained is included in a defined set of providers.

''(d) DISPUTE RESOLUTION PROCEDURES.—The information required under subsection (a) includes a description of the processes adopted by the plan pursuant to section 503(b), including—

''(1) descriptions thereof relating specifically to—

''(A) coverage decisions,

''(B) internal review of coverage decisions, and

''(C) any external review of coverage decisions, and

''(2) the procedures and time frames applicable to each step of the processes referred to in subparagraphs (A), (B), and (C) of paragraph (1).

''(e) INFORMATION AVAILABLE ON REQUEST.—

''(1) ACCESS TO PLAN BENEFIT INFORMATION IN ELECTRONIC FORM.—

''(A) IN GENERAL.—In addition to the information required to be provided under section 104(b)(4), a group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) shall, upon written request (made not more frequently than annually), make available to participants and beneficiaries, in a generally recognized electronic format, the following information:

''(i) the latest summary plan description, including the latest summary of material modifications; and

''(ii) the actual plan provisions setting forth the benefits available under the plan to the extent such information relates to the coverage options under the plan available to the participant or beneficiary. A reasonable charge may be made to cover the cost of providing

such information in such generally recognized electronic format. The Secretary may by regulation prescribe a maximum amount which will constitute a reasonable charge under the preceding sentence.

''(B) ALTERNATIVE ACCESS.—The requirements of this paragraph may be met by making such information generally available (rather than upon request) on the Internet or on a proprietary computer network in a format which is readily accessible to participants and beneficiaries.

''(2) ADDITIONAL INFORMATION TO BE PROVIDED ON REQUEST.—

''(A) INCLUSION IN SUMMARY PLAN DESCRIPTION OF SUMMARY OF ADDITIONAL INFORMATION.—The information required under subsection (a) includes a summary description of the types of information required by this subsection to be made available to participants and beneficiaries on request.

''(B) INFORMATION REQUIRED FROM PLANS AND ISSUERS ON REQUEST.—In addition to information required to be included in summary plan descriptions under this subsection, a

group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) shall provide the following information to a participant or beneficiary on request:

"(i) NETWORK CHARACTERISTICS.—If the plan (or issuer) utilizes a defined set of providers under contract with the plan (or issuer), a detailed list of the names of such providers and their geographic location, set forth separately with respect to primary care providers and with respect to specialists.

"(ii) CARE MANAGEMENT INFORMATION.—A description of the circumstances under which, and the extent to which, the plan has special disease management programs or programs for persons with disabilities, indicating whether these programs are voluntary or mandatory and whether a significant benefit differential results from participation in such programs.

"(iii) INCLUSION OF DRUGS AND BIOLOGICALS IN FORMULARIES.—A state-

ment of whether a specific drug or biological is included in a formulary used to determine benefits under the plan and a description of the procedures for considering requests for any patient-specific waivers.

''(iv) PROCEDURES FOR DETERMINING EXCLUSIONS BASED ON MEDICAL NECESSITY OR EXPERIMENTAL TREATMENTS.—Upon receipt by the participant or beneficiary of any notification of an adverse coverage decision based on a determination relating to medical necessity or an experimental treatment or technology, a description of the procedures and medically-based criteria used in such decision.

''(v) PREAUTHORIZATION AND UTILIZATION REVIEW PROCEDURES.—Upon receipt by the participant or beneficiary of any notification of an adverse coverage decision, a description of the basis on which any preauthorization requirement or any utilization review requirement has resulted in such decision.

''(vi) ACCREDITATION STATUS OF HEALTH INSURANCE ISSUERS AND SERV-

ICE PROVIDERS.—A description of the accreditation and licencing status (if any) of each health insurance issuer offering health insurance coverage in connection with the plan and of any utilization review organization utilized by the issuer or the plan, together with the name and address of the accrediting or licencing authority.

''(vii) MEASURES OF ENROLLEE SATISFACTION.—The latest information (if any) maintained by the plan, or by any health insurance issuer offering health insurance coverage in connection with the plan, relating to enrollee satisfaction.

''(viii) QUALITY PERFORMANCE MEASURES.—The latest information (if any) maintained by the plan, or by any health insurance issuer offering health insurance coverage in connection with the plan, relating to quality of performance of the delivery of medical care with respect to coverage options offered under the plan and of health care professionals and facilities providing medical care under the plan.

"(C) INFORMATION REQUIRED FROM HEALTH CARE PROFESSIONALS ON REQUEST.—Any health care professional treating a participant or beneficiary under a group health plan shall provide to the participant or beneficiary, on request, a description of his or her professional qualifications (including board certification status, licensing status, and accreditation status, if any), privileges, and experience and a general description by category (including salary, fee-for-service, capitation, and such other categories as may be specified in regulations of the Secretary) of the applicable method by which such professional is compensated in connection with the provision of such medical care.

"(D) INFORMATION REQUIRED FROM HEALTH CARE FACILITIES ON REQUEST.—Any health care facility from which a participant or beneficiary has sought treatment under a group health plan shall provide to the participant or beneficiary, on request, a description of the facility's corporate form or other organizational form and all forms of licensing and accreditation status (if any) assigned to the facility by standard-setting organizations.

''(f) ACCESS TO INFORMATION RELEVANT TO THE COVERAGE OPTIONS UNDER WHICH THE PARTICIPANT OR BENEFICIARY IS ELIGIBLE TO ENROLL.—In addition to information otherwise required to be made available under this section, a group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) shall, upon written request (made not more frequently than annually), make available to a participant in connection with a period of enrollment the summary plan description for any coverage option under the plan under which the participant is eligible to enroll and any information described in clauses (i), (ii), (iii), (vi), (vii), and (viii) of subsection (e)(2)(B).

''(g) ADVANCE NOTICE OF CHANGES IN DRUG FORMULARIES.—Not later than 30 days before the effective of date of any exclusion of a specific drug or biological from any drug formulary under the plan that is used in the treatment of a chronic illness or disease, the plan shall take such actions as are necessary to reasonably ensure that plan participants are informed of such exclusion. The requirements of this subsection may be satisfied—

''(1) by inclusion of information in publications broadly distributed by plan sponsors, employers, or employee organizations,

''(2) by electronic means of communication (including the Internet or proprietary computer networks in a format which is readily accessible to participants),

''(3) by timely informing participants who, under an ongoing program maintained under the plan, have submitted their names for such notification, or

''(4) by any other reasonable means of timely informing plan participants.

''(h) DEFINITIONS.—For purposes of this section—

''(1) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning provided such term under section 503(b)(6).

''(2) MEDICAL CARE.—The term 'medical care' has the meaning provided such term under section 733(a)(2).

''(3) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning provided such term under section 733(b)(1).

''(4) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning provided such term under section 733(b)(2).''.

(b) CONFORMING AMENDMENTS.—

(1) Section 102(b) of such Act (29 U.S.C. 1022(b)) is amended—

(A) by striking ''section 733(a)(1)'' each place it appears and inserting ''section 503(b)(6)''; and

(B) by inserting before the period at the end the following: ''; and, in the case of a group health plan (as defined in section 111(h)(1)), the information required to be included under section 111(a)''.

(2) The table of contents in section 1 of such Act is amended by striking the item relating to section 111 and inserting the following new items:

''Sec. 111. Disclosure by group health plans.
''Sec. 112. Repeal and effective date.''.

SEC. 1102. EFFECTIVE DATE AND RELATED RULES.

(a) IN GENERAL.—The amendments made by this subtitle shall apply with respect to plan years beginning on or after January 1 of the second calendar year following the date of the enactment of this Act. The Secretary shall first issue all regulations necessary to carry out the amendments made by this subtitle before such date.

(b) LIMITATION ON ENFORCEMENT ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this subtitle, against a group health plan or health insurance issuer with respect to a violation of

a requirement imposed by such amendments before the date of issuance of final regulations issued in connection with such requirement, if the plan or issuer has sought to comply in good faith with such requirement.

(c) ASSURING COORDINATION.—The Secretary of Labor, the Secretary of Health and Human Services, and the Secretary of the Treasury shall ensure, through the execution of an interagency memorandum of understanding among such Secretaries, that—

(1) regulations, rulings, and interpretations issued by such Secretaries relating to the same matter over which two or more such Secretaries have responsibility under the provisions of this subtitle, subtitle B of title II, and subtitle B of title III (and the amendments made thereby) are administered so as to have the same effect at all times, and

(2) coordination of policies relating to enforcing the same requirements through such Secretaries in order to have a coordinated enforcement strategy that avoids duplication of enforcement efforts and assigns priorities in enforcement.

Subtitle C—New Procedures and Access to Courts for Grievances Arising Under Group Health Plans

SEC. 1201. SPECIAL RULES FOR GROUP HEALTH PLANS.

(a) IN GENERAL.—Section 503 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1133) is amended—

(1) by inserting ''(a) IN GENERAL.—'' after ''SEC. 503.'';

(2) by inserting ''(other than a group health plan)'' after ''employee benefit plan''; and

(3) by adding at the end the following new subsection:

''(b) SPECIAL RULES FOR GROUP HEALTH PLANS.—

''(1) COVERAGE DETERMINATIONS.—Every group health plan shall—

''(A) provide adequate notice in writing in accordance with this subsection to any participant or beneficiary of any adverse coverage decision with respect to benefits of such participant or beneficiary under the plan, setting forth the specific reasons for such coverage decision and any rights of review provided under the

plan, written in a manner calculated to be understood by the participant,

"(B) provide such notice in writing also to any treating medical care provider of such participant or beneficiary, if such provider has claimed reimbursement for any item or service involved in such coverage decision, or if a claim submitted by the provider initiated the proceedings leading to such decision,

"(C) afford a reasonable opportunity to any participant or beneficiary who is in receipt of the notice of such adverse coverage decision, and who files a written request for review of the initial coverage decision within 180 days after receipt of the notice of the initial decision, for a full and fair de novo review of the decision by an appropriate named fiduciary who did not make the initial decision, and

"(D) meet the additional requirements of this subsection.

"(2) TIME LIMITS FOR MAKING INITIAL COVERAGE DECISIONS FOR BENEFITS AND COMPLETING INTERNAL APPEALS.—

"(A) TIME LIMITS FOR DECIDING REQUESTS FOR BENEFIT PAYMENTS, REQUESTS

FOR ADVANCE DETERMINATION OF COVERAGE, AND REQUESTS FOR REQUIRED DETERMINATION OF MEDICAL NECESSITY.—Except as provided in subparagraph (B)—

"(i) INITIAL DECISIONS.—If a request for benefit payments, a request for advance determination of coverage, or a request for required determination of medical necessity is submitted to a group health plan in such reasonable form as may be required under the plan, the plan shall issue in writing an initial coverage decision on the request before the end of the initial decision period under paragraph (9)(J) following the filing completion date. Failure to issue a coverage decision on such a request before the end of the period required under this clause shall be treated as an adverse coverage decision for purposes of internal review under clause (ii).

"(ii) INTERNAL REVIEWS OF INITIAL DENIALS.—Upon the written request of a participant or beneficiary for review of an initial adverse coverage decision under clause (i), a review by an appropriate

named fiduciary (subject to paragraph (3)) of the initial coverage decision shall be completed, including issuance by the plan of a written decision affirming, reversing, or modifying the initial coverage decision, setting forth the grounds for such decision, before the end of the internal review period following the review filing date. Such decision shall be treated as the final decision of the plan, subject to any applicable reconsideration under paragraph (4). Failure to issue before the end of such period such a written decision requested under this clause shall be treated as a final decision affirming the initial coverage decision, subject to any applicable reconsideration under paragraph (4).

''(B) TIME LIMITS FOR MAKING COVERAGE DECISIONS RELATING TO URGENT AND EMERGENCY MEDICAL CARE AND FOR COMPLETING INTERNAL APPEALS.—

''(i) INITIAL DECISIONS.—A group health plan shall issue in writing an initial coverage decision on any request for expedited advance determination of coverage or

for expedited required determination of medical necessity submitted, in such reasonable form as may be required under the plan—

"(I) before the end of the urgent decision period under paragraph (9)(L), in cases involving urgent medical care but not involving emergency medical care, or

"(II) before the end of the emergency decision period under paragraph (9)(M), in cases involving emergency medical care,

following the filing completion date. Failure to approve or deny such a request before the end of the applicable decision period shall be treated as a denial of the request for purposes of internal review under clause (ii).

"(ii) INTERNAL REVIEWS OF INITIAL DENIALS.—Upon the written request of a participant or beneficiary for review of an initial adverse coverage decision under clause (i), a review by an appropriate named fiduciary (subject to paragraph (3))

of the initial coverage decision shall be completed, including issuance by the plan of a written decision affirming, reversing, or modifying the initial converge decision, setting forth the grounds for the decision—

"(I) before the end of the urgent decision period under paragraph (9)(L), in cases involving urgent medical care but not involving emergency medical care, or

"(II) before the end of the emergency decision period under paragraph (9)(M), in cases involving emergency medical care,

following the review filing date. Such decision shall be treated as the final decision of the plan, subject to any applicable reconsideration under paragraph (4). Failure to issue before the end of the applicable decision period such a written decision requested under this clause shall be treated as a final decision affirming the initial coverage decision, subject to any applicable reconsideration under paragraph (4).

''(3) PHYSICIANS MUST REVIEW INITIAL COVERAGE DECISIONS INVOLVING MEDICAL APPROPRIATENESS OR NECESSITY OR EXPERIMENTAL TREATMENT.—If an initial coverage decision under paragraph (2)(A)(i) or (2)(B)(i) is based on a determination that provision of a particular item or service is excluded from coverage under the terms of the plan because the provision of such item or service does not meet the plan's requirements for medical appropriateness or necessity or would constitute experimental treatment or technology, the review under paragraph (2)(A)(ii) or (2)(B)(ii), to the extent that it relates to medical appropriateness or necessity or to experimental treatment or technology, shall be conducted by a physician who is selected to serve as an appropriate named fiduciary under the plan and who did not make the initial denial.

''(4) ELECTIVE EXTERNAL REVIEW BY INDEPENDENT MEDICAL EXPERT AND RECONSIDERATION OF INITIAL REVIEW DECISION.—

''(A) IN GENERAL.—The requirements of subparagraphs (B), (C) and (D) shall apply—

''(i) in the case of any failure to timely issue a coverage decision upon internal review which is deemed to be an adverse

coverage decision under paragraph (2)(A)(ii) or (2)(B)(ii) (thereby failing to constitute a coverage decision for which specific reasons have been set forth as required under paragraph (1)(A)), and

''(ii) in the case of any adverse coverage decision which is not reversed upon a review conducted pursuant to paragraph (1)(C) (including any review pursuant to paragraph (2)(A)(ii) or (2)(B)(ii)), if such coverage decision is based on a determination that provision of a particular item or service is excluded from coverage under the terms of the plan because the provision of such item or service—

''(I) does not meet the plan's requirements for medical appropriateness or necessity, or

''(II) would constitute experimental treatment or technology.

''(B) LIMITS ON ALLOWABLE ADVANCE PAYMENTS.—The review under this paragraph in connection with an adverse coverage decision shall be available subject to any requirement of the plan (unless waived by the plan for financial

or other reasons) for payment in advance to the plan by the participant or beneficiary seeking review of an amount not to exceed the greater of—

"(i) the lesser of $100 or 10 percent of the cost of the medical care involved in the decision, or

"(ii) $25,

with each such dollar amount subject to compounded annual adjustments in the same manner and to the same extent as apply under section 215(i) of the Social Security Act, except that, for any calendar year, such amount as so adjusted shall be deemed, solely for such calendar year, to be equal to such amount rounded to the nearest $10. No such payment may be required in the case of any participant or beneficiary whose enrollment under the plan is paid for, in whole or in part, under a State plan under title XIX or XXI of the Social Security Act. Any such advance payment shall be subject to reimbursement if the recommendation of the independent medical expert or experts under subparagraph (C)(iii) is to reverse or modify the coverage decision.

"(C) RECONSIDERATION OF INITIAL REVIEW DECISION.—In any case in which a participant or beneficiary who has received an adverse decision of the plan upon initial review of the coverage decision and who has not commenced review of the initial coverage decision under section 502 makes a request in writing, within 30 days after the date of such review decision, for reconsideration of such review decision, the terms of the plan shall provide for a procedure for such reconsideration under which—

"(i) one or more independent medical experts will be selected in accordance with subparagraph (E) to review the coverage decision described in subparagraph (A) to determine whether such decision was in accordance with the terms of the plan and this title,

"(ii) the record for review (including a specification of the terms of the plan and other criteria serving as the basis for the initial review decision) will be presented to such expert or experts and maintained in

a manner which will ensure confidentiality of such record,

"(iii) such expert or experts will report in writing to the plan their recommendation, based on the determination made under clause (i), as to whether such coverage decision should be affirmed, modified, or reversed, setting forth the grounds (including the clinical basis) for the recommendation, and

"(iv) a physician who did not make the initial review decision will reconsider the initial review decision to determine whether such decision was in accordance with the terms of the plan and this title and will issue a written decision affirming, modifying, or reversing the initial review decision, taking into account any recommendations reported to the plan pursuant to clause (iii), and setting forth the grounds for the decision.

"(D) TIME LIMITS FOR RECONSIDERATION.—Any review under this paragraph shall be completed before the end of the reconsideration period (as defined in paragraph (9)(O))

following the review filing date in connection with such review. The decision under this paragraph affirming, reversing, or modifying the initial review decision of the plan shall be the final decision of the plan. Failure to issue a written decision before the end of the reconsideration period in any reconsideration requested under this paragraph shall be treated as a final decision affirming the initial review decision of the plan.

''(E) INDEPENDENT MEDICAL EXPERTS.—

''(i) IN GENERAL.—For purposes of this paragraph, the term 'independent medical expert' means, in connection with any coverage decision by a group health plan, a professional—

''(I) who is a physician or, if appropriate, another medical professional,

''(II) who has appropriate credentials and has attained recognized expertise in the applicable medical field,

"(III) who was not involved in the initial decision or any earlier review thereof, and

"(IV) who is selected in accordance with clause (ii) and meets the requirements of clause (iii).

"(ii) SELECTION OF MEDICAL EXPERTS.—An independent medical expert is selected in accordance with this clause if—

"(I) the expert is selected by an intermediary which itself meets the requirements of clause (iii), by means of a method which ensures that the identity of the expert is not disclosed to the plan, any health insurance issuer offering health insurance coverage to the aggrieved participant or beneficiary in connection with the plan, and the aggrieved participant or beneficiary under the plan, and the identities of the plan, the issuer, and the aggrieved participant or beneficiary are not disclosed to the expert,

"(II) the expert is selected, by an appropriately credentialed panel of

physicians meeting the requirements of clause (iii) established by a fully accredited teaching hospital meeting such requirements,

''(III) the expert is selected by an organization described in section 1152(1)(A) of the Social Security Act which meets the requirements of clause (iii),

''(IV) the expert is selected by an external review organization which meets the requirements of clause (iii) and is accredited by a private standard-setting organization meeting such requirements and recognized as such by the Secretary, or

''(V) the expert is selected, by an intermediary or otherwise, in a manner that is, under regulations issued pursuant to negotiated rulemaking, sufficient to ensure the expert's independence,

and the method of selection is devised to reasonably ensure that the expert selected

meets the independence requirements of clause (iii).

''(iii) INDEPENDENCE REQUIREMENTS.—An independent medical expert or another entity described in clause (ii) meets the independence requirements of this clause if—

''(I) the expert or entity is not affiliated with any related party,

''(II) any compensation received by such expert or entity in connection with the external review is reasonable and not contingent on any decision rendered by the expert or entity,

''(III) under the terms of the plan and any health insurance coverage offered in connection with the plan, the plan and the issuer (if any) have no recourse against the expert or entity in connection with the external review, and

''(IV) the expert or entity does not otherwise have a conflict of interest with a related party as determined

under any regulations which the Secretary may prescribe.

''(iv) RELATED PARTY.—For purposes of clause (ii)(I), the term 'related party' means—

''(I) the plan or any health insurance issuer offering health insurance coverage in connection with the plan (or any officer, director, or management employee of such plan or issuer),

''(II) the physician or other medical care provider that provided the medical care involved in the coverage decision,

''(III) the institution at which the medical care involved in the coverage decision is provided,

''(IV) the manufacturer of any drug or other item that was included in the medical care involved in the coverage decision, or

''(V) any other party determined under any regulations which the Secretary may prescribe to have a sub-

stantial interest in the coverage decision .

"(v) AFFILIATED.—For purposes of clause (iii)(I), the term 'affiliated' means, in connection with any entity, having a familial, financial, or professional relationship with, or interest in, such entity.

"(F) INAPPLICABILITY WITH RESPECT TO ITEMS AND SERVICES SPECIFICALLY EXCLUDED FROM COVERAGE.—An adverse coverage decision based on a determination that an item or service is excluded from coverage under the terms of the plan shall not be subject to review under this paragraph, unless such determination is found in such decision to be based solely on the fact that the item or service—

"(i) does not meet the plan's requirements for medical appropriateness or necessity, or

"(ii) would constitute experimental treatment or technology (as defined under the plan).

"(5) PERMITTED ALTERNATIVES TO REQUIRED INTERNAL REVIEW.—

"(A) IN GENERAL.—A group health plan shall not be treated as failing to meet the requirements under paragraphs (2)(A)(ii) and (2)(B)(ii) relating to review of initial coverage decisions for benefits, if—

"(i) in lieu of the procedures relating to review under paragraphs (2)(A)(ii) and (2)(B)(ii) and in accordance with such regulations (if any) as may be prescribed by the Secretary—

"(I) the aggrieved participant or beneficiary elects in the request for the review an alternative dispute resolution procedure which is available under the plan with respect to similarly situated participants and beneficiaries, or

"(II) in the case of any such plan or portion thereof which is established and maintained pursuant to a bona fide collective bargaining agreement, the plan provides for a procedure by which such disputes are resolved by means of any alternative dispute resolution procedure,

"(ii) the time limits not exceeding the time limits otherwise applicable under paragraphs (2)(A)(ii) and (2)(B)(ii) are incorporated in such alternative dispute resolution procedure,

"(iii) any applicable requirement for review by a physician under paragraph (3), unless waived by the participant or beneficiary (in a manner consistent with such regulations as the Secretary may prescribe to ensure equitable procedures), is incorporated in such alternative dispute resolution procedure, and

"(iv) the plan meets the additional requirements of subparagraph (B).

In any case in which a procedure described in subclause (I) or (II) of clause (i) is utilized and an alternative dispute resolution procedure is voluntarily elected by the aggrieved participant or beneficiary, the plan may require or allow (in a manner consistent with such regulations as the Secretary may prescribe to ensure equitable procedures) the aggrieved participant or beneficiary to waive review of the coverage decision under paragraph (3), to waive further review of

the coverage decision under paragraph (4) or section 502, and to elect an alternative means of external review (other than review under paragraph (4)).

''(B) ADDITIONAL REQUIREMENTS.—The requirements of this subparagraph are met if the means of resolution of dispute allow for adequate presentation by the aggrieved participant or beneficiary of scientific and medical evidence supporting the position of such participant or beneficiary.

''(6) PERMITTED ALTERNATIVES TO REQUIRED EXTERNAL REVIEW.—A group health plan shall not be treated as failing to meet the requirements of this subsection in connection with review of coverage decisions under paragraph (4) if the aggrieved participant or beneficiary elects to utilize a procedure in connection with such review which is made generally available under the plan (in a manner consistent with such regulations as the Secretary may prescribe to ensure equitable procedures) under which—

''(A) the plan agrees in advance of the recommendations of the independent medical expert or experts under paragraph (4)(C)(iii) to

render a final decision in accordance with such recommendations, and

"(B) the participant or beneficiary waives in advance any right to review of the final decision under section 502.

"(7) SPECIAL RULE FOR ACCESS TO SPECIALTY CARE.— In the case of a request for advance determination of coverage consisting of a request by a physician for a determination of coverage of the services of a specialist with respect to any condition, if coverage of the services of such specialist for such condition is otherwise provided under the plan, the initial coverage decision referred to in subparagraph (A)(i) or (B)(i) of paragraph (2) shall be issued within the specialty decision period. For purposes of this paragraph, the term 'specialist' means, with respect to a condition, a physician who has a high level of expertise through appropriate training and experience (including, in the case of a child, appropriate pediatric expertise) to treat the condition.

"(8) GROUP HEALTH PLAN DEFINED.—For purposes of this section—

"(A) IN GENERAL.—The term 'group health plan' shall have the meaning provided in section 733(a).

"(B) TREATMENT OF PARTNERSHIPS.—The provisions of paragraphs (1), (2), and (3) of section 732(d) shall apply.

"(9) OTHER DEFINITIONS.—For purposes of this subsection—

"(A) REQUEST FOR BENEFIT PAYMENTS.—The term 'request for benefit payments' means a request, for payment of benefits by a group health plan for medical care, which is made by or on behalf of a participant or beneficiary after such medical care has been provided.

"(B) REQUIRED DETERMINATION OF MEDICAL NECESSITY.—The term 'required determination of medical necessity' means a determination required under a group health plan solely that proposed medical care meets, under the facts and circumstances at the time of the determination, the plan's requirements for medical appropriateness or necessity (which may be subject to exceptions under the plan for fraud or misrepresentation), irrespective of whether the proposed medical care otherwise meets other terms and conditions of coverage, but only if such determination does not constitute

an advance determination of coverage (as defined in subparagraph (C)).

''(C) ADVANCE DETERMINATION OF COVERAGE.—The term 'advance determination of coverage' means a determination under a group health plan that proposed medical care meets, under the facts and circumstances at the time of the determination, the plan's terms and conditions of coverage (which may be subject to exceptions under the plan for fraud or misrepresentation).

''(D) REQUEST FOR ADVANCE DETERMINATION OF COVERAGE.—The term 'request for advance determination of coverage' means a request for an advance determination of coverage of medical care which is made by or on behalf of a participant or beneficiary before such medical care is provided.

''(E) REQUEST FOR EXPEDITED ADVANCE DETERMINATION OF COVERAGE.—The term 'request for expedited advance determination of coverage' means a request for advance determination of coverage, in any case in which the proposed medical care constitutes urgent medical care or emergency medical care.

"(F) REQUEST FOR REQUIRED DETERMINATION OF MEDICAL NECESSITY.—The term 'request for required determination of medical necessity' means a request for a required determination of medical necessity for medical care which is made by or on behalf of a participant or beneficiary before the medical care is provided.

"(G) REQUEST FOR EXPEDITED REQUIRED DETERMINATION OF MEDICAL NECESSITY.—The term 'request for expedited required determination of medical necessity' means a request for required determination of medical necessity in any case in which the proposed medical care constitutes urgent medical care or emergency medical care.

"(H) URGENT MEDICAL CARE.—The term 'urgent medical care' means medical care in any case in which an appropriate physician has certified in writing (or as otherwise provided in regulations of the Secretary) that failure to provide the participant or beneficiary with such medical care within 45 days can reasonably be expected to result in either—

"(i) the imminent death of the participant or beneficiary, or

"(ii) the immediate, serious, and irreversible deterioration of the health of the participant or beneficiary which will significantly increase the likelihood of death of, or irreparable harm to, the participant or beneficiary.

"(I) EMERGENCY MEDICAL CARE.—The term 'emergency medical care' means medical care in any case in which an appropriate physician has certified in writing (or as otherwise provided in regulations of the Secretary)—

"(i) that failure to immediately provide the care to the participant or beneficiary could reasonably be expected to result in—

"(I) placing the health of such participant or beneficiary (or, with respect to such a participant or beneficiary who is a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

"(II) serious impairment to bodily functions, or

"(III) serious dysfunction of any bodily organ or part,

or

"(ii) that immediate provision of the care is necessary because the participant or beneficiary has made or is at serious risk of making an attempt to harm himself or herself or another individual.

"(J) INITIAL DECISION PERIOD.—The term 'initial decision period' means a period of 30 days, or such longer period as may be prescribed in regulations of the Secretary.

"(K) INTERNAL REVIEW PERIOD.—The term 'internal review period' means a period of 30 days, or such longer period as may be prescribed in regulations of the Secretary.

"(L) URGENT DECISION PERIOD.—The term 'urgent decision period' means a period of 10 days, or such longer period as may be prescribed in regulations of the Secretary.

"(M) EMERGENCY DECISION PERIOD.—The term 'emergency decision period' means a period of 72 hours, or such longer period as may be prescribed in regulations of the Secretary.

''(N) SPECIALTY DECISION PERIOD.—The term 'specialty decision period' means a period of 72 hours, or such longer period as may be prescribed in regulations of the Secretary.

''(O) RECONSIDERATION PERIOD.—The term 'reconsideration period' means a period of 25 days, or such longer period as may be prescribed in regulations of the Secretary, except that—

''(i) in the case of a decision involving urgent medical care, such term means the urgent decision period, and

''(ii) in the case of a decision involving emergency medical care, such term means the emergency decision period.

''(P) FILING COMPLETION DATE.—The term 'filing completion date' means, in connection with a group health plan, the date as of which the plan is in receipt of all information reasonably required (in writing or in such other reasonable form as may be specified by the plan) to make an initial coverage decision.

''(Q) REVIEW FILING DATE.—The term 'review filing date' means, in connection with a group health plan, the date as of which the ap-

propriate named fiduciary (or the independent medical expert or experts in the case of a review under paragraph (4)) is in receipt of all information reasonably required (in writing or in such other reasonable form as may be specified by the plan) to make a decision to affirm, modify, or reverse a coverage decision.

''(R) MEDICAL CARE.—The term 'medical care' has the meaning provided such term by section 733(a)(2).

''(S) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning provided such term by section 733(b)(1).

''(T) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning provided such term by section 733(b)(2).

''(U) WRITTEN OR IN WRITING.—

''(i) IN GENERAL.—A request or decision shall be deemed to be 'written' or 'in writing' if such request or decision is presented in a generally recognized printable or electronic format. The Secretary may by regulation provide for presentation of information otherwise required to be in writ-

ten form in such other forms as may be appropriate under the circumstances.

''(ii) MEDICAL APPROPRIATENESS OR EXPERIMENTAL TREATMENT DETERMINATIONS.—For purposes of this subparagraph, in the case of a request for advance determination of coverage, a request for expedited advance determination of coverage, a request for required determination of medical necessity, or a request for expedited required determination of medical necessity, if the decision on such request is conveyed to the provider of medical care or to the participant or beneficiary by means of telephonic or other electronic communications, such decision shall be treated as a written decision.''.

(b) CIVIL PENALTIES.—

(1) IN GENERAL.—Section 502(c) of such Act (29 U.S.C. 1132(c)) is amended by redesignating paragraphs (6) and (7) as paragraphs (7) and (8), respectively, and by inserting after paragraph (5) the following new paragraph:

''(6)(A)(i) In any case in which—

''(I) a benefit under a group health plan (as defined in section 503(b)(8)) is not timely provided to a participant or beneficiary pursuant to a final decision of the plan which was not in accordance with the terms of the plan or this title, and

''(II) such final decision of the plan is contrary to a recommendation described in section 503(b)(4)(C)(iii),

any person acting in the capacity of a fiduciary of such plan so as to cause such failure may, in the court's discretion, be liable to the aggrieved participant or beneficiary for a civil penalty.

''(ii) Such civil penalty shall be in the amount of up to $250 a day from the date on which the recommendation was made to the plan until the date the failure to provide benefits is corrected, up to a total amount not to exceed $100,000.

''(B) In any action commenced under subsection (a) by a participant or beneficiary with respect to a group health plan (as defined in section 503(b)(8)) in which the plaintiff alleges that a person, in the capacity of a fiduciary and in violation of the terms of the plan or this title, has taken an action resulting in an adverse coverage decision in violation of the terms of the plan, or has failed to take an action for which such person is responsible

under the plan and which is necessary under the plan for a favorable coverage decision, upon finding in favor of the plaintiff, if such action was commenced after a final decision of the plan upon review which included a review under section 503(b)(4) or such action was commenced under subsection (b)(4) of this section, the court shall cause to be served on the defendant an order requiring the defendant—

''(i) to cease and desist from the alleged action or failure to act, and

''(ii) to pay to the plaintiff a reasonable attorney's fee and other reasonable costs relating to the prosecution of the action on the charges on which the plaintiff prevails.

The remedies provided under this subparagraph shall be in addition to remedies otherwise provided under this section.

''(C)(i) The Secretary may assess a civil penalty against a person acting in the capacity of a fidicuary of one or more group health plans (as defined in section 503(b)(8)) for—

''(I) any pattern or practice of repeated adverse coverage decisions in violation of the terms of the plan or plans or this title, or

''(II) any pattern or practice of repeated violations of the requirements of section 503 with respect to such plan or plans.

Such penalty shall be payable only upon proof by clear and convincing evidence of such pattern or practice.

''(ii) Such penalty shall be in an amount not to exceed the lesser of—

''(I) 5 percent of the aggregate value of benefits shown by the Secretary to have not been provided, or unlawfully delayed in violation of section 503, under such pattern or practice, or

''(II) $100,000.

''(iii) Any person acting in the capacity of a fiduciary of a group health plan or plans who has engaged in any such pattern or practice with respect to such plans, upon the petition of the Secretary, may be removed by the court from that position, and from any other involvement, with respect to such plan or plans, and may be precluded from returning to any such position or involvement for a period determined by the court.''.

(2) CONFORMING AMENDMENT.—Section 502(a)(6) of such Act (29 U.S.C. 1132(a)(6)) is amended by striking ''(6)'' and inserting ''(7)''.

(c) EXPEDITED COURT REVIEW.—Section 502 of such Act (29 U.S.C. 1132) is amended—

(1) in subsection (a)(8), by striking ''or'' at the end;

(2) in subsection (a)(9), by striking the period and inserting ''; or'';

(3) by adding at the end of subsection (a) the following new paragraph:

''(10) by a participant or beneficiary for appropriate relief under subsection (b)(4).''.

(4) by adding at the end of subsection (b) the following new paragraph:

''(4) In any case in which exhaustion of administrative remedies in accordance with paragraph (2)(A)(ii) or (2)(B)(ii) of section 503(b) otherwise necessary for an action for relief under paragraph (1)(B) or (3) of subsection (a) has not been obtained and it is demonstrated to the court by means of certification by an appropriate physician that such exhaustion is not reasonably attainable under the facts and circumstances without undue risk of irreparable harm to the health of the participant or beneficiary, a civil action may be brought by a participant or beneficiary to obtain appropriate equitable relief. Any determinations made under paragraph (2)(A)(ii) or (2)(B)(ii) of section 503(b) made while an action under this paragraph is pending shall be given due consideration by the court in any such action.''.

(d) STANDARD OF REVIEW UNAFFECTED.—The standard of review under section 502 of the Employee Retirement Income Security Act of 1974 (as amended by this section) shall continue on and after the date of the enactment of this Act to be the standard of review which was applicable under such section as of immediately before such date.

(e) CONCURRENT JURISDICTION.—Section 502(e)(1) of such Act (29 U.S.C. 1132(e)(1)) is amended—

(1) in the first sentence, by striking ''under subsection (a)(1)(B) of this section'' and inserting ''under subsection (a)(1)(A) for relief under subsection (c)(6), under subsection (a)(1)(B), and under subsection (b)(4)''; and

(2) in the last sentence, by striking ''of actions under paragraphs (1)(B) and (7) of subsection (a) of this section'' and inserting ''of actions under paragraph (1)(A) of subsection (a) for relief under subsection (c)(6) and of actions under paragraphs (1)(B) and (7) of subsection (a) and paragraph (4) of subsection (b)''.

SEC. 1202. EFFECTIVE DATE.

(a) IN GENERAL.—The amendments made by this subtitle shall apply with respect to grievances arising in plan years beginning on or after January 1 of the second

calendar year following the date of the enactment of this Act. The Secretary shall first issue all regulations necessary to carry out the amendments made by this subtitle before such date.

(b) LIMITATION ON ENFORCEMENT ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this subtitle, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by such amendments before the date of issuance of final regulations issued in connection with such requirement, if the plan or issuer has sought to comply in good faith with such requirement.

(c) COLLECTIVE BARGAINING AGREEMENTS.—Any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this subtitle shall not be treated as a termination of such collective bargaining agreement.

Subtitle D—Affordable Health Coverage for Employees of Small Businesses

SEC. 1301. SHORT TITLE OF SUBTITLE.

This subtitle may be cited as the ''Small Business Affordable Health Coverage Act of 1998''.

SEC. 1302. RULES GOVERNING ASSOCIATION HEALTH PLANS.

(a) IN GENERAL.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding after part 7 the following new part:

''PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

''SEC. 801. ASSOCIATION HEALTH PLANS.

''(a) IN GENERAL.—For purposes of this part, the term 'association health plan' means a group health plan—

''(1) whose sponsor is (or is deemed under this part to be) described in subsection (b), and

''(2) under which at least one option of health insurance coverage offered by a health insurance issuer (which may include, among other options, managed care options, point of service options, and preferred provider options) is provided to participants and beneficiaries, unless, for any plan year, such coverage remains unavailable to the plan despite good faith efforts exercised by the plan to secure such coverage.

''(b) SPONSORSHIP.—The sponsor of a group health plan is described in this subsection if such sponsor—

''(1) is organized and maintained in good faith, with a constitution and bylaws specifically stating its

purpose and providing for periodic meetings on at least an annual basis, as a trade association, an industry association (including a rural electric cooperative association or a rural telephone cooperative association), a professional association, or a chamber of commerce (or similar business association, including a corporation or similar organization that operates on a cooperative basis (within the meaning of section 1381 of the Internal Revenue Code of 1986)), for substantial purposes other than that of obtaining or providing medical care,

''(2) is established as a permanent entity which receives the active support of its members and collects from its members on a periodic basis dues or payments necessary to maintain eligibility for membership in the sponsor, and

''(3) does not condition membership, such dues or payments, or coverage under the plan on the basis of health status-related factors with respect to the employees of its members (or affiliated members), or the dependents of such employees, and does not condition such dues or payments on the basis of group health plan participation.

Any sponsor consisting of an association of entities which meet the requirements of paragraphs (1) and (2) shall be deemed to be a sponsor described in this subsection.

"SEC. 802. CERTIFICATION OF ASSOCIATION HEALTH PLANS.

''(a) IN GENERAL.—The applicable authority shall prescribe by regulation a procedure under which, subject to subsection (b), the applicable authority shall certify association health plans which apply for certification as meeting the requirements of this part.

''(b) STANDARDS.—Under the procedure prescribed pursuant to subsection (a), the applicable authority shall certify an association health plan as meeting the requirements of this part only if the applicable authority is satisfied that—

''(1) such certification—

''(A) is administratively feasible,

''(B) is not adverse to the interests of the individuals covered under the plan, and

''(C) is protective of the rights and benefits of the individuals covered under the plan, and

''(2) the applicable requirements of this part are met (or, upon the date on which the plan is to commence operations, will be met) with respect to the plan.

''(c) REQUIREMENTS APPLICABLE TO CERTIFIED PLANS.—An association health plan with respect to which certification under this part is in effect shall meet the applicable requirements of this part, effective on the date of certification (or, if later, on the date on which the plan is to commence operations).

''(d) REQUIREMENTS FOR CONTINUED CERTIFICATION.—The applicable authority may provide by regulation for continued certification of association health plans under this part, including requirements relating to commencement of new benefit options by plans which do not consist of health insurance coverage.

''(e) CLASS CERTIFICATION FOR FULLY INSURED PLANS.—The applicable authority shall establish a class certification procedure for association health plans under which all benefits consist of health insurance coverage. Under such procedure, the applicable authority shall provide for the granting of certification under this part to the plans in each class of such association health plans upon appropriate filing under such procedure in connection with plans in such class and payment of the prescribed fee under section 807(a).

"SEC. 803. REQUIREMENTS RELATING TO SPONSORS AND BOARDS OF TRUSTEES.

''(a) SPONSOR.—The requirements of this subsection are met with respect to an association health plan if—

''(1) the sponsor (together with its immediate predecessor, if any) has met (or is deemed under this part to have met) for a continuous period of not less than 3 years ending with the date of the application for certification under this part, the requirements of paragraphs (1) and (2) of section 801(b), and

''(2) the sponsor meets (or is deemed under this part to meet) the requirements of section 801(b)(3).

''(b) BOARD OF TRUSTEES.—The requirements of this subsection are met with respect to an association health plan if the following requirements are met:

''(1) FISCAL CONTROL.—The plan is operated, pursuant to a trust agreement, by a board of trustees which has complete fiscal control over the plan and which is responsible for all operations of the plan.

''(2) RULES OF OPERATION AND FINANCIAL CONTROLS.—The board of trustees has in effect rules of operation and financial controls, based on a 3-year plan of operation, adequate to carry out the

terms of the plan and to meet all requirements of this title applicable to the plan.

''(3) RULES GOVERNING RELATIONSHIP TO PARTICIPATING EMPLOYERS AND TO CONTRACTORS.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the members of the board of trustees are individuals selected from individuals who are the owners, officers, directors, or employees of the participating employers or who are partners in the participating employers and actively participate in the business.

''(B) LIMITATION.—

''(i) GENERAL RULE.—Except as provided in clauses (ii) and (iii), no such member is an owner, officer, director, or employee of, or partner in, a contract administrator or other service provider to the plan.

''(ii) LIMITED EXCEPTION FOR PROVIDERS OF SERVICES SOLELY ON BEHALF OF THE SPONSOR.—Officers or employees of a sponsor which is a service provider (other than a contract administrator) to the plan may be members of the board if

they constitute not more than 25 percent of the membership of the board and they do not provide services to the plan other than on behalf of the sponsor.

"(iii) TREATMENT OF PROVIDERS OF MEDICAL CARE.—In the case of a sponsor which is an association whose membership consists primarily of providers of medical care, clause (i) shall not apply in the case of any service provider described in subparagraph (A) who is a provider of medical care under the plan.

"(C) SOLE AUTHORITY.—The board has sole authority to approve applications for participation in the plan and to contract with a service provider to administer the day-to-day affairs of the plan.

"(c) TREATMENT OF FRANCHISE NETWORKS.—In the case of a group health plan which is established and maintained by a franchiser for a franchise network consisting of its franchisees—

"(1) the requirements of subsection (a) and section 801(a)(1) shall be deemed met if such requirements would otherwise be met if the franchiser were deemed to be the sponsor referred to in section

801(b), such network were deemed to be an association described in section 801(b), and each franchisee were deemed to be a member (of the association and the sponsor) referred to in section 801(b), and

''(2) the requirements of section 804(a)(1) shall be deemed met.

''(d) CERTAIN COLLECTIVELY BARGAINED PLANS.—

''(1) IN GENERAL.—In the case of a group health plan described in paragraph (2)—

''(A) the requirements of subsection (a) and section 801(a)(1) shall be deemed met,

''(B) the joint board of trustees shall be deemed a board of trustees with respect to which the requirements of subsection (b) are met, and

''(C) the requirements of section 804 shall be deemed met.

''(2) REQUIREMENTS.—A group health plan is described in this paragraph if—

''(A) the plan is a multiemployer plan, or

''(B) the plan is in existence on April 1, 1997, and would be described in section 3(40)(A)(i) but solely for the failure to meet the requirements of section 3(40)(C)(ii).

"SEC. 804. PARTICIPATION AND COVERAGE REQUIREMENTS.

"(a) COVERED EMPLOYERS AND INDIVIDUALS.—The requirements of this subsection are met with respect to an association health plan if, under the terms of the plan—

"(1) all participating employers must be members or affiliated members of the sponsor, except that, in the case of a sponsor which is a professional association or other individual-based association, if at least one of the officers, directors, or employees of an employer, or at least one of the individuals who are partners in an employer and who actively participates in the business, is a member or affiliated member of the sponsor, participating employers may also include such employer, and

"(2) all individuals commencing coverage under the plan after certification under this part must be—

"(A) active or retired owners (including self-employed individuals), officers, directors, or employees of, or partners in, participating employers, or

"(B) the beneficiaries of individuals described in subparagraph (A).

''(b) COVERAGE OF PREVIOUSLY UNINSURED EMPLOYEES.—

''(1) IN GENERAL.—Subject to paragraph (2), the requirements of this subsection are met with respect to an association health plan if, under the terms of the plan, no affiliated member of the sponsor may be offered coverage under the plan as a participating employer, unless—

''(A) the affiliated member was an affiliated member on the date of certification under this part, or

''(B) during the 12-month period preceding the date of the offering of such coverage, the affiliated member has not maintained or contributed to a group health plan with respect to any of its employees who would otherwise be eligible to participate in such association health plan.

''(2) LIMITATION.—The requirements of this subsection shall apply only in the case of plans which were in existence on the date of the enactment of the Small Business Affordable Health Coverage Act of 1998.

''(c) INDIVIDUAL MARKET UNAFFECTED.—The requirements of this subsection are met with respect to an

association health plan if, under the terms of the plan, no participating employer may provide health insurance coverage in the individual market for any employee not covered under the plan which is similar to the coverage contemporaneously provided to employees of the employer under the plan, if such exclusion of the employee from coverage under the plan is based on a health status-related factor with respect to the employee and such employee would, but for such exclusion on such basis, be eligible for coverage under the plan.

''(d) PROHIBITION OF DISCRIMINATION AGAINST EMPLOYERS AND EMPLOYEES ELIGIBLE TO PARTICIPATE.—The requirements of this subsection are met with respect to an association health plan if—

''(1) under the terms of the plan, no employer meeting the preceding requirements of this section is excluded as a participating employer, unless participation or contribution requirements of the type referred to in section 2711 of the Public Health Service Act are not met with respect to the excluded employer,

''(2) the applicable requirements of sections 701, 702, and 703 are met with respect to the plan, and

''(3) applicable benefit options under the plan are actively marketed to all eligible participating employers.

"SEC. 805. OTHER REQUIREMENTS RELATING TO PLAN DOCUMENTS, CONTRIBUTION RATES, AND BENEFIT OPTIONS.

''(a) IN GENERAL.—The requirements of this section are met with respect to an association health plan if the following requirements are met:

''(1) CONTENTS OF GOVERNING INSTRUMENTS.—The instruments governing the plan include a written instrument, meeting the requirements of an instrument required under section 402(a)(1), which—

''(A) provides that the board of trustees serves as the named fiduciary required for plans under section 402(a)(1) and serves in the capacity of a plan administrator (referred to in section 3(16)(A)),

''(B) provides that the sponsor of the plan is to serve as plan sponsor (referred to in section 3(16)(B)), and

''(C) incorporates the requirements of section 806.

''(2) CONTRIBUTION RATES MUST BE NON-DISCRIMINATORY.—

''(A) The contribution rates for any participating small employer do not vary on the basis of the claims experience of such employer and do not vary on the basis of the type of business or industry in which such employer is engaged.

''(B) Nothing in this title or any other provision of law shall be construed to preclude an association health plan, or a health insurance issuer offering health insurance coverage in connection with an association health plan, from

''(i) setting contribution rates based on the claims experience of the plan, or

''(ii) varying contribution rates for small employers in a State to the extent that such rates could vary using the same methodology employed in such State for regulating premium rates in the small group market,

subject to the requirements of section 702(b) relating to contribution rates.

"(3) FLOOR FOR NUMBER OF COVERED INDIVIDUALS WITH RESPECT TO CERTAIN PLANS.—If any benefit option under the plan does not consist of health insurance coverage, the plan has as of the beginning of the plan year not fewer than 1,000 participants and beneficiaries.

"(4) MARKETING REQUIREMENTS.—

"(A) IN GENERAL.—If a benefit option which consists of health insurance coverage is offered under the plan, State-licensed insurance agents shall be used to distribute to small employers coverage which does not consist of health insurance coverage in a manner comparable to the manner in which such agents are used to distribute health insurance coverage.

"(B) STATE-LICENSED INSURANCE AGENTS.—For purposes of subparagraph (A), the term 'State-licensed insurance agents' means one or more agents who are licensed in a State and are subject to the laws of such State relating to licensure, qualification, testing, examination, and continuing education of persons authorized to offer, sell, or solicit health insurance coverage in such State.

''(5) REGULATORY REQUIREMENTS.—Such other requirements as the applicable authority may prescribe by regulation as necessary to carry out the purposes of this part.

''(b) ABILITY OF ASSOCIATION HEALTH PLANS TO DESIGN BENEFIT OPTIONS.—Nothing in this part or any provision of State law (as defined in section 514(c)(1)) shall be construed to preclude an association health plan, or a health insurance issuer offering health insurance coverage in connection with an association health plan, from exercising its sole discretion in selecting the specific items and services consisting of medical care to be included as benefits under such plan or coverage, except (subject to section 514) in the case of any law to the extent that it (1) prohibits an exclusion of a specific disease from such coverage, or (2) is not preempted under section 731(a)(1) with respect to matters governed by section 711 or 712.

''SEC. 806. MAINTENANCE OF RESERVES AND PROVISIONS FOR SOLVENCY FOR PLANS PROVIDING HEALTH BENEFITS IN ADDITION TO HEALTH INSURANCE COVERAGE.

''(a) IN GENERAL.—The requirements of this section are met with respect to an association health plan if—

''(1) the benefits under the plan consist solely of health insurance coverage, or

''(2) if the plan provides any additional benefit options which do not consist of health insurance coverage, the plan—

''(A) establishes and maintains reserves with respect to such additional benefit options, in amounts recommended by the qualified actuary, consisting of—

''(i) a reserve sufficient for unearned contributions,

''(ii) a reserve sufficient for benefit liabilities which have been incurred, which have not been satisfied, and for which risk of loss has not yet been transferred, and for expected administrative costs with respect to such benefit liabilities,

''(iii) a reserve sufficient for any other obligations of the plan, and

''(iv) a reserve sufficient for a margin of error and other fluctuations, taking into account the specific circumstances of the plan,

and

''(B) establishes and maintains aggregate and specific excess/stop loss insurance and solvency indemnification, with respect to such ad-

ditional benefit options for which risk of loss has not yet been transferred, as follows:

''(i) The plan shall secure aggregate excess/stop loss insurance for the plan with an attachment point which is not greater than 125 percent of expected gross annual claims. The applicable authority may by regulation provide for upward adjustments in the amount of such percentage in specified circumstances in which the plan specifically provides for and maintains reserves in excess of the amounts required under subparagraph (A).

''(ii) The plan shall secure specific excess/stop loss insurance for the plan with an attachment point which is at least equal to an amount recommended by the plan's qualified actuary (but not more than $200,000). The applicable authority may by regulation provide for adjustments in the amount of such insurance in specified circumstances in which the plan specifically provides for and maintains reserves in excess of the amounts required under subparagraph (A).

"(iii) The plan shall secure indemnification insurance for any claims which the plan is unable to satisfy by reason of a plan termination.

Any regulations prescribed by the applicable authority pursuant to clause (i) or (ii) of subparagraph (B) may allow for such adjustments in the required levels of excess/stop loss insurance as the qualified actuary may recommend, taking into account the specific circumstances of the plan.

"(b) MINIMUM SURPLUS IN ADDITION TO CLAIMS RESERVES.—The requirements of this subsection are met if the plan establishes and maintains surplus in an amount at least equal to $2,000,000, reduced in accordance with a scale, prescribed in regulations of the applicable authority to an amount not less than $500,000, based on the level of aggregate and specific excess/stop loss insurance provided with respect to such plan.

"(c) ADDITIONAL REQUIREMENTS.—In the case of any association health plan described in subsection (a)(2), the applicable authority may provide such additional requirements relating to reserves and excess/stop loss insurance as the applicable authority considers appropriate. Such requirements may be provided, by regulation or oth-

erwise, with respect to any such plan or any class of such plans.

''(d) ADJUSTMENTS FOR EXCESS/STOP LOSS INSURANCE.—The applicable authority may provide for adjustments to the levels of reserves otherwise required under subsections (a) and (b) with respect to any plan or class of plans to take into account excess/stop loss insurance provided with respect to such plan or plans.

''(e) ALTERNATIVE MEANS OF COMPLIANCE.—The applicable authority may permit an association health plan described in subsection (a)(2) to substitute, for all or part of the requirements of this section (except subsection (a)(2)(B)(iii)), such security, guarantee, hold-harmless arrangement, or other financial arrangement as the applicable authority determines to be adequate to enable the plan to fully meet all its financial obligations on a timely basis and is otherwise no less protective of the interests of participants and beneficiaries than the requirements for which it is substituted. The applicable authority may take into account, for purposes of this subsection, evidence provided by the plan or sponsor which demonstrates an assumption of liability with respect to the plan. Such evidence may be in the form of a contract of indemnification, lien, bonding, insurance, letter of credit, recourse under applicable terms of the plan in the form of assessments

of participating employers, security, or other financial arrangement.

"(f) MEASURES TO ENSURE CONTINUED PAYMENT OF BENEFITS BY CERTAIN PLANS IN DISTRESS.—

"(1) PAYMENTS BY CERTAIN PLANS TO ASSOCIATION HEALTH PLAN FUND.—

"(A) IN GENERAL.—In the case of an association health plan described in subsection (a)(2), the requirements of this subsection are met if the plan makes payments into the Association Health Plan Fund under this subparagraph when they are due. Such payments shall consist of annual payments in the amount of $5,000, and, in addition to such annual payments, such supplemental payments as the Secretary may determine to be necessary under paragraph (2). Payments under this paragraph are payable to the Fund at the time determined by the Secretary. Initial payments are due in advance of certification under this part. Payments shall continue to accrue until a plan's assets are distributed pursuant to a termination procedure.

"(B) PENALTIES FOR FAILURE TO MAKE PAYMENTS.—If any payment is not made by a

plan when it is due, a late payment charge of not more than 100 percent of the payment which was not timely paid shall be payable by the plan to the Fund.

''(C) CONTINUED DUTY OF THE SECRETARY.—The Secretary shall not cease to carry out the provisions of paragraph (2) on account of the failure of a plan to pay any payment when due.

''(2) PAYMENTS BY SECRETARY TO CONTINUE EXCESS STOP/LOSS INSURANCE COVERAGE AND INDEMNIFICATION INSURANCE COVERAGE FOR CERTAIN PLANS.—In any case in which the applicable authority determines that there is, or that there is reason to believe that there will be, (A) a failure to take necessary corrective actions under section 809(a) with respect to an association health plan described in subsection (a)(2), or (B) a termination of such a plan under section 809(b) or 810(b)(8) (and, if the applicable authority is not the Secretary, certifies such determination to the Secretary), the Secretary shall determine the amounts necessary to make payments to an insurer (designated by the Secretary) to maintain in force excess/stop loss insurance coverage or indemnification insurance cov-

erage for such plan, if the Secretary determines that there is a reasonable expectation that, without such payments, claims would not be satisfied by reason of termination of such coverage. The Secretary shall, to the extent provided in advance in appropriation Acts, pay such amounts so determined to the insurer designated by the Secretary.

''(3) ASSOCIATION HEALTH PLAN FUND.—

''(A) IN GENERAL.—There is established on the books of the Treasury a fund to be known as the 'Association Health Plan Fund'. The Fund shall be available for making payments pursuant to paragraph (2). The Fund shall be credited with payments received pursuant to paragraph (1)(A), penalties received pursuant to paragraph (1)(B), and earnings on investments of amounts of the Fund under subparagraph (B).

''(B) INVESTMENT.—Whenever the Secretary determines that the moneys of the fund are in excess of current needs, the Secretary may request the investment of such amounts as the Secretary determines advisable by the Secretary of the Treasury in obligations issued or guaranteed by the United States.

''(g) EXCESS/STOP LOSS INSURANCE.—For purposes of this section—

''(1) AGGREGATE EXCESS/STOP LOSS INSURANCE.—The term 'aggregate excess/stop loss insurance' means, in connection with an association health plan, a contract—

''(A) under which an insurer (meeting such minimum standards as may be prescribed in regulations of the applicable authority) provides for payment to the plan with respect to aggregate claims under the plan in excess of an amount or amounts specified in such contract,

''(B) which is guaranteed renewable, and

''(C) which allows for payment of premiums by any third party on behalf of the insured plan.

''(2) SPECIFIC EXCESS/STOP LOSS INSURANCE.—The term 'specific excess/stop loss insurance' means , in connection with an association health plan, a contract—

''(A) under which an insurer (meeting such minimum standards as may be prescribed in regulations of the applicable authority) provides for payment to the plan with respect to claims under the plan in connection with a covered individual in excess of an amount or amounts

specified in such contract in connection with such covered individual,

"(B) which is guaranteed renewable, and

"(C) which allows for payment of premiums by any third party on behalf of the insured plan.

"(h) INDEMNIFICATION INSURANCE.—For purposes of this section, the term 'indemnification insurance' means, in connection with an association health plan, a contract—

"(1) under which an insurer (meeting such minimum standards as may be prescribed in regulations of the applicable authority) provides for payment to the plan with respect to claims under the plan which the plan is unable to satisfy by reason of a termination pursuant to section 809(b) (relating to mandatory termination),

"(2) which is guaranteed renewable and noncancellable for any reason (except as may be provided in regulations of the applicable authority), and

"(3) which allows for payment of premiums by any third party on behalf of the insured plan.

"(i) RESERVES.—For purposes of this section, the term 'reserves' means, in connection with an association health plan, plan assets which meet the fiduciary stand-

ards under part 4 and such additional requirements regarding liquidity as may be prescribed in regulations of the applicable authority.

''(j) REGULATIONS PRESCRIBED UNDER NEGOTIATED RULEMAKING.—The regulations under this section shall be prescribed under negotiated rulemaking in accordance with subchapter III of chapter 5 of title 5, United States Code, except that, in establishing the negotiated rulemaking committee for purposes of such rulemaking, the applicable authority shall include among persons invited to membership on the committee at least one of each of the following:

''(1) a representative of the National Association of Insurance Commissioners,

''(2) a representative of the American Academy of Actuaries,

''(3) a representative of the State governments, or their interests,

''(4) a representative of existing self-insured arrangements, or their interests,

''(5) a representative of associations of the type referred to in section 801(b)(1), or their interests, and

''(6) a representative of multiemployer plans that are group health plans, or their interests.

"SEC. 807. REQUIREMENTS FOR APPLICATION AND RELATED REQUIREMENTS.

"(a) FILING FEE.—Under the procedure prescribed pursuant to section 802(a), an association health plan shall pay to the applicable authority at the time of filing an application for certification under this part a filing fee in the amount of $5,000, which shall be available in the case of the Secretary, to the extent provided in appropriation Acts, for the sole purpose of administering the certification procedures applicable with respect to association health plans.

"(b) INFORMATION TO BE INCLUDED IN APPLICATION FOR CERTIFICATION.—An application for certification under this part meets the requirements of this section only if it includes, in a manner and form prescribed in regulations of the applicable authority, at least the following information:

"(1) IDENTIFYING INFORMATION.—The names and addresses of—

"(A) the sponsor, and

"(B) the members of the board of trustees of the plan.

"(2) STATES IN WHICH PLAN INTENDS TO DO BUSINESS.—The States in which participants and beneficiaries under the plan are to be located and

the number of them expected to be located in each such State.

''(3) BONDING REQUIREMENTS.—Evidence provided by the board of trustees that the bonding requirements of section 412 will be met as of the date of the application or (if later) commencement of operations.

''(4) PLAN DOCUMENTS.—A copy of the documents governing the plan (including any bylaws and trust agreements), the summary plan description, and other material describing the benefits that will be provided to participants and beneficiaries under the plan.

''(5) AGREEMENTS WITH SERVICE PROVIDERS.—A copy of any agreements between the plan and contract administrators and other service providers.

''(6) FUNDING REPORT.—In the case of association health plans providing benefits options in addition to health insurance coverage, a report setting forth information with respect to such additional benefit options determined as of a date within the 120-day period ending with the date of the application, including the following:

"(A) RESERVES.—A statement, certified by the board of trustees of the plan, and a statement of actuarial opinion, signed by a qualified actuary, that all applicable requirements of section 806 are or will be met in accordance with regulations which the applicable authority shall prescribe.

"(B) ADEQUACY OF CONTRIBUTION RATES.—A statement of actuarial opinion, signed by a qualified actuary, which sets forth a description of the extent to which contribution rates are adequate to provide for the payment of all obligations and the maintenance of required reserves under the plan for the 12-month period beginning with such date within such 120-day period, taking into account the expected coverage and experience of the plan. If the contribution rates are not fully adequate, the statement of actuarial opinion shall indicate the extent to which the rates are inadequate and the changes needed to ensure adequacy.

"(C) CURRENT AND PROJECTED VALUE OF ASSETS AND LIABILITIES.—A statement of actuarial opinion signed by a qualified actuary, which sets forth the current value of the assets

and liabilities accumulated under the plan and a projection of the assets, liabilities, income, and expenses of the plan for the 12-month period referred to in subparagraph (B). The income statement shall identify separately the plan's administrative expenses and claims.

"(D) COSTS OF COVERAGE TO BE CHARGED AND OTHER EXPENSES.—A statement of the costs of coverage to be charged, including an itemization of amounts for administration, reserves, and other expenses associated with the operation of the plan.

"(E) OTHER INFORMATION.—Any other information which may be prescribed in regulations of the applicable authority as necessary to carry out the purposes of this part.

"(c) FILING NOTICE OF CERTIFICATION WITH STATES.—A certification granted under this part to an association health plan shall not be effective unless written notice of such certification is filed with the applicable State authority of each State in which at least 25 percent of the participants and beneficiaries under the plan are located. For purposes of this subsection, an individual shall be considered to be located in the State in which a

known address of such individual is located or in which such individual is employed.

''(d) NOTICE OF MATERIAL CHANGES.—In the case of any association health plan certified under this part, descriptions of material changes in any information which was required to be submitted with the application for the certification under this part shall be filed in such form and manner as shall be prescribed in regulations of the applicable authority. The applicable authority may require by regulation prior notice of material changes with respect to specified matters which might serve as the basis for suspension or revocation of the certification.

''(e) REPORTING REQUIREMENTS FOR CERTAIN ASSOCIATION HEALTH PLANS.—An association health plan certified under this part which provides benefit options in addition to health insurance coverage for such plan year shall meet the requirements of section 103 by filing an annual report under such section which shall include information described in subsection (b)(6) with respect to the plan year and, notwithstanding section 104(a)(1)(A), shall be filed with the applicable authority not later than 90 days after the close of the plan year (or on such later date as may be prescribed by the applicable authority).

''(f) ENGAGEMENT OF QUALIFIED ACTUARY.—The board of trustees of each association health plan which

provides benefits options in addition to health insurance coverage and which is applying for certification under this part or is certified under this part shall engage, on behalf of all participants and beneficiaries, a qualified actuary who shall be responsible for the preparation of the materials comprising information necessary to be submitted by a qualified actuary under this part. The qualified actuary shall utilize such assumptions and techniques as are necessary to enable such actuary to form an opinion as to whether the contents of the matters reported under this part—

''(1) are in the aggregate reasonably related to the experience of the plan and to reasonable expectations, and

''(2) represent such actuary's best estimate of anticipated experience under the plan.

The opinion by the qualified actuary shall be made with respect to, and shall be made a part of, the annual report.

''SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TERMINATION.

''Except as provided in section 809(b), an association health plan which is or has been certified under this part may terminate (upon or at any time after cessation of accruals in benefit liabilities) only if the board of trustees—

''(1) not less than 60 days before the proposed termination date, provides to the participants and beneficiaries a written notice of intent to terminate stating that such termination is intended and the proposed termination date,

''(2) develops a plan for winding up the affairs of the plan in connection with such termination in a manner which will result in timely payment of all benefits for which the plan is obligated, and

''(3) submits such plan in writing to the applicable authority.

Actions required under this section shall be taken in such form and manner as may be prescribed in regulations of the applicable authority.

''SEC. 809. CORRECTIVE ACTIONS AND MANDATORY TERMINATION.

''(a) ACTIONS TO AVOID DEPLETION OF RESERVES.—An association health plan which is certified under this part and which provides benefits other than health insurance coverage shall continue to meet the requirements of section 806, irrespective of whether such certification continues in effect. The board of trustees of such plan shall determine quarterly whether the requirements of section 806 are met. In any case in which the board determines that there is reason to believe that there

is or will be a failure to meet such requirements, or the applicable authority makes such a determination and so notifies the board, the board shall immediately notify the qualified actuary engaged by the plan, and such actuary shall, not later than the end of the next following month, make such recommendations to the board for corrective action as the actuary determines necessary to ensure compliance with section 806. Not later than 30 days after receiving from the actuary recommendations for corrective actions, the board shall notify the applicable authority (in such form and manner as the applicable authority may prescribe by regulation) of such recommendations of the actuary for corrective action, together with a description of the actions (if any) that the board has taken or plans to take in response to such recommendations. The board shall thereafter report to the applicable authority, in such form and frequency as the applicable authority may specify to the board, regarding corrective action taken by the board until the requirements of section 806 are met.

''(b) MANDATORY TERMINATION.—In any case in which—

''(1) the applicable authority has been notified under subsection (a) of a failure of an association health plan which is or has been certified under this part and is described in section 806(a)(2) to meet

the requirements of section 806 and has not been notified by the board of trustees of the plan that corrective action has restored compliance with such requirements, and

''(2) the applicable authority determines that there is a reasonable expectation that the plan will continue to fail to meet the requirements of section 806,

the board of trustees of the plan shall, at the direction of the applicable authority, terminate the plan and, in the course of the termination, take such actions as the applicable authority may require, including satisfying any claims referred to in section 806(a)(2)(B)(iii) and recovering for the plan any liability under subsection (a)(2)(B)(iii) or (e) of section 806, as necessary to ensure that the affairs of the plan will be, to the maximum extent possible, wound up in a manner which will result in timely provision of all benefits for which the plan is obligated.

''SEC. 810. TRUSTEESHIP BY THE SECRETARY OF INSOLVENT ASSOCIATION HEALTH PLANS PROVIDING HEALTH BENEFITS IN ADDITION TO HEALTH INSURANCE COVERAGE.

''(a) APPOINTMENT OF SECRETARY AS TRUSTEE FOR INSOLVENT PLANS.—Whenever the Secretary determines that an association health plan which is or has been cer-

tified under this part and which is described in section 806(a)(2) will be unable to provide benefits when due or is otherwise in a financially hazardous condition as defined in regulations of such Secretary, the Secretary shall, upon notice to the plan, apply to the appropriate United States district court for appointment of the Secretary as trustee to administer the plan for the duration of the insolvency. The plan may appear as a party and other interested persons may intervene in the proceedings at the discretion of the court. The court shall appoint such Secretary trustee if the court determines that the trusteeship is necessary to protect the interests of the participants and beneficiaries or providers of medical care or to avoid any unreasonable deterioration of the financial condition of the plan. The trusteeship of such Secretary shall continue until the conditions described in the first sentence of this subsection are remedied or the plan is terminated.

''(b) POWERS AS TRUSTEE.—The Secretary, upon appointment as trustee under subsection (a), shall have the power—

''(1) to do any act authorized by the plan, this title, or other applicable provisions of law to be done by the plan administrator or any trustee of the plan,

''(2) to require the transfer of all (or any part) of the assets and records of the plan to the Secretary as trustee,

''(3) to invest any assets of the plan which the Secretary holds in accordance with the provisions of the plan, regulations of the Secretary, and applicable provisions of law,

''(4) to require the sponsor, the plan administrator, any participating employer, and any employee organization representing plan participants to furnish any information with respect to the plan which the Secretary as trustee may reasonably need in order to administer the plan,

''(5) to collect for the plan any amounts due the plan and to recover reasonable expenses of the trusteeship,

''(6) to commence, prosecute, or defend on behalf of the plan any suit or proceeding involving the plan,

''(7) to issue, publish, or file such notices, statements, and reports as may be required under regulations of the Secretary or by any order of the court,

''(8) to terminate the plan (or provide for its termination accordance with section 809(b)) and liquidate the plan assets, to restore the plan to the re-

sponsibility of the sponsor, or to continue the trusteeship,

''(9) to provide for the enrollment of plan participants and beneficiaries under appropriate coverage options, and

''(10) to do such other acts as may be necessary to comply with this title or any order of the court and to protect the interests of plan participants and beneficiaries and providers of medical care.

''(c) NOTICE OF APPOINTMENT.—As soon as practicable after the Secretary's appointment as trustee, the Secretary shall give notice of such appointment to—

''(1) the sponsor and plan administrator,

''(2) each participant,

''(3) each participating employer, and

''(4) if applicable, each employee organization which, for purposes of collective bargaining, represents plan participants.

''(d) ADDITIONAL DUTIES.—Except to the extent inconsistent with the provisions of this title, or as may be otherwise ordered by the court, the Secretary, upon appointment as trustee under this section, shall be subject to the same duties as those of a trustee under section 704

of title 11, United States Code, and shall have the duties of a fiduciary for purposes of this title.

''(e) OTHER PROCEEDINGS.—An application by the Secretary under this subsection may be filed notwithstanding the pendency in the same or any other court of any bankruptcy, mortgage foreclosure, or equity receivership proceeding, or any proceeding to reorganize, conserve, or liquidate such plan or its property, or any proceeding to enforce a lien against property of the plan.

''(f) JURISDICTION OF COURT.—

''(1) IN GENERAL.—Upon the filing of an application for the appointment as trustee or the issuance of a decree under this section, the court to which the application is made shall have exclusive jurisdiction of the plan involved and its property wherever located with the powers, to the extent consistent with the purposes of this section, of a court of the United States having jurisdiction over cases under chapter 11 of title 11, United States Code. Pending an adjudication under this section such court shall stay, and upon appointment by it of the Secretary as trustee, such court shall continue the stay of, any pending mortgage foreclosure, equity receivership, or other proceeding to reorganize, conserve, or liquidate the plan, the sponsor, or property of such plan or spon-

sor, and any other suit against any receiver, conservator, or trustee of the plan, the sponsor, or property of the plan or sponsor. Pending such adjudication and upon the appointment by it of the Secretary as trustee, the court may stay any proceeding to enforce a lien against property of the plan or the sponsor or any other suit against the plan or the sponsor.

''(2) VENUE.—An action under this section may be brought in the judicial district where the sponsor or the plan administrator resides or does business or where any asset of the plan is situated. A district court in which such action is brought may issue process with respect to such action in any other judicial district.

''(g) PERSONNEL.—In accordance with regulations of the Secretary, the Secretary shall appoint, retain, and compensate accountants, actuaries, and other professional service personnel as may be necessary in connection with the Secretary's service as trustee under this section.

''SEC. 811. STATE ASSESSMENT AUTHORITY.

''(a) IN GENERAL.—Notwithstanding section 514, a State may impose by law a contribution tax on an association health plan described in section 806(a)(2), if the plan commenced operations in such State after the date of the

enactment of the Small Business Affordable Health Coverage Act of 1998.

''(b) CONTRIBUTION TAX.—For purposes of this section, the term 'contribution tax' imposed by a State on an association health plan means any tax imposed by such State if—

''(1) such tax is computed by applying a rate to the amount of premiums or contributions, with respect to individuals covered under the plan who are residents of such State, which are received by the plan from participating employers located in such State or from such individuals,

''(2) the rate of such tax does not exceed the rate of any tax imposed by such State on premiums or contributions received by insurers or health maintenance organizations for health insurance coverage offered in such State in connection with a group health plan,

''(3) such tax is otherwise nondiscriminatory, and

''(4) the amount of any such tax assessed on the plan is reduced by the amount of any tax or assessment otherwise imposed by the State on premiums, contributions, or both received by insurers or health maintenance organizations for health insur-

ance coverage, aggregate excess/stop loss insurance (as defined in section 806(g)(1)), specific excess/stop loss insurance (as defined in section 806(g)(2)), other insurance related to the provision of medical care under the plan, or any combination thereof provided by such insurers or health maintenance organizations in such State in connection with such plan.

"SEC. 812. SPECIAL RULES FOR CHURCH PLANS.

"(a) ELECTION FOR CHURCH PLANS.—Notwithstanding section 4(b)(2), if a church, a convention or association of churches, or an organization described in section 3(33)(C)(i) maintains a church plan which is a group health plan (as defined in section 733(a)(1)), and such church, convention, association, or organization makes an election with respect to such plan under this subsection (in such form and manner as the Secretary may by regulation prescribe), then the provisions of this section shall apply to such plan, with respect to benefits provided under such plan consisting of medical care, as if section 4(b)(2) did not contain an exclusion for church plans. Nothing in this subsection shall be construed to render any other section of this title applicable to church plans, except to the extent that such other section is incorporated by reference in this section.

"(b) EFFECT OF ELECTION.—

''(1) PREEMPTION OF STATE INSURANCE LAWS REGULATING COVERED CHURCH PLANS.—Subject to paragraphs (2) and (3), this section shall supersede any and all State laws which regulate insurance insofar as they may now or hereafter regulate church plans to which this section applies or trusts established under such church plans.

''(2) GENERAL STATE INSURANCE REGULATION UNAFFECTED.—

''(A) IN GENERAL.—Except as provided in subparagraph (B) and paragraph (3), nothing in this section shall be construed to exempt or relieve any person from any provision of State law which regulates insurance.

''(B) CHURCH PLANS NOT TO BE DEEMED INSURANCE COMPANIES OR INSURERS.—Neither a church plan to which this section applies, nor any trust established under such a church plan, shall be deemed to be an insurance company or other insurer or to be engaged in the business of insurance for purposes of any State law purporting to regulate insurance companies or insurance contracts.

''(3) PREEMPTION OF CERTAIN STATE LAWS RELATING TO PREMIUM RATE REGULATION AND

BENEFIT MANDATES.—The provisions of subsections (a)(2)(B) and (b) of section 805 shall apply with respect to a church plan to which this section applies in the same manner and to the same extent as such provisions apply with respect to association health plans.

''(4) DEFINITIONS.—For purposes of this subsection—

''(A) STATE LAW.—The term 'State law' includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

''(B) STATE.—The term 'State' includes a State, any political subdivision thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of church plans covered by this section.

''(c) REQUIREMENTS FOR COVERED CHURCH PLANS.—

''(1) FIDUCIARY RULES AND EXCLUSIVE PURPOSE.—A fiduciary shall discharge his duties with

respect to a church plan to which this section applies—

"(A) for the exclusive purpose of:

"(i) providing benefits to participants and their beneficiaries; and

"(ii) defraying reasonable expenses of administering the plan;

"(B) with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and

"(C) in accordance with the documents and instruments governing the plan.

The requirements of this paragraph shall not be treated as not satisfied solely because the plan assets are commingled with other church assets, to the extent that such plan assets are separately accounted for.

"(2) CLAIMS PROCEDURE.—In accordance with regulations of the Secretary, every church plan to which this section applies shall—

"(A) provide adequate notice in writing to any participant or beneficiary whose claim for

benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant;

"(B) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate fiduciary of the decision denying the claim; and

"(C) provide a written statement to each participant describing the procedures established pursuant to this paragraph.

"(3) ANNUAL STATEMENTS.—In accordance with regulations of the Secretary, every church plan to which this section applies shall file with the Secretary an annual statement—

"(A) stating the names and addresses of the plan and of the church, convention, or association maintaining the plan (and its principal place of business);

"(B) certifying that it is a church plan to which this section applies and that it complies with the requirements of paragraphs (1) and (2);

"(C) identifying the States in which participants and beneficiaries under the plan are or likely will be located during the 1-year period covered by the statement; and

"(D) containing a copy of a statement of actuarial opinion signed by a qualified actuary that the plan maintains capital, reserves, insurance, other financial arrangements, or any combination thereof adequate to enable the plan to fully meet all of its financial obligations on a timely basis.

"(4) DISCLOSURE.—At the time that the annual statement is filed by a church plan with the Secretary pursuant to paragraph (3), a copy of such statement shall be made available by the Secretary to the State insurance commissioner (or similar official) of any State. The name of each church plan and sponsoring organization filing an annual statement in compliance with paragraph (3) shall be published annually in the Federal Register.

"(c) ENFORCEMENT.—The Secretary may enforce the provisions of this section in a manner consistent with section 502, to the extent applicable with respect to actions under section 502(a)(5), and with section 3(33)(D), except that, other than for the purpose of seeking a tem-

porary restraining order, a civil action may be brought with respect to the plan's failure to meet any requirement of this section only if the plan fails to correct its failure within the correction period described in section 3(33)(D). The other provisions of part 5 (except sections 501(a), 503, 512, 514, and 515) shall apply with respect to the enforcement and administration of this section.

''(d) DEFINITIONS AND OTHER RULES.—For purposes of this section—

''(1) IN GENERAL.—Except as otherwise provided in this section, any term used in this section which is defined in any provision of this title shall have the definition provided such term by such provision.

''(2) SEMINARY STUDENTS.—Seminary students who are enrolled in an institution of higher learning described in section 3(33)(C)(iv) and who are treated as participants under the terms of a church plan to which this section applies shall be deemed to be employees as defined in section 3(6) if the number of such students constitutes an insignificant portion of the total number of individuals who are treated as participants under the terms of the plan.

''SEC. 813. DEFINITIONS AND RULES OF CONSTRUCTION.

''(a) DEFINITIONS.—For purposes of this part—

''(1) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning provided in section 733(a)(1) (after applying subsection (b) of this section).

''(2) MEDICAL CARE.—The term 'medical care' has the meaning provided in section 733(a)(2).

''(3) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning provided in section 733(b)(1).

''(4) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning provided in section 733(b)(2).

''(5) APPLICABLE AUTHORITY.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the term 'applicable authority' means, in connection with an association health plan—

''(i) the State recognized pursuant to subsection (c) of section 506 as the State to which authority has been delegated in connection with such plan, or

''(ii) if there if no State referred to in clause (i), the Secretary.

''(B) EXCEPTIONS.—

"(i) JOINT AUTHORITIES.—Where such term appears in section 808(3), section 807(e) (in the first instance), section 809(a) (in the second instance), section 809(a) (in the fourth instance), and section 809(b)(1), such term means, in connection with an association health plan, the Secretary and the State referred to in subparagraph (A)(i) (if any) in connection with such plan.

"(ii) REGULATORY AUTHORITIES.—Where such term appears in section 802(a) (in the first instance), section 802(d), section 802(e), section 803(d), section 805(a)(5), section 806(a)(2), section 806(b), section 806(c), section 806(d), paragraphs (1)(A) and (2)(A) of section 806(g), section 806(h), section 806(i), section 807(a) (in the second instance), section 807(b), section 807(d), section 807(e) (in the second instance), section 808 (in the matter after paragraph (3)), and section 809(a) (in the third instance), such term means, in connection with an association health plan, the Secretary.

''(6) HEALTH STATUS-RELATED FACTOR.—The term 'health status-related factor' has the meaning provided in section 733(d)(2).

''(7) INDIVIDUAL MARKET.—

''(A) IN GENERAL.—The term 'individual market' means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

''(B) TREATMENT OF VERY SMALL GROUPS.—

''(i) IN GENERAL.—Subject to clause (ii), such term includes coverage offered in connection with a group health plan that has fewer than 2 participants as current employees or participants described in section 732(d)(3) on the first day of the plan year.

''(ii) STATE EXCEPTION.—Clause (i) shall not apply in the case of health insurance coverage offered in a State if such State regulates the coverage described in such clause in the same manner and to the same extent as coverage in the small group market (as defined in section 2791(e)(5) of

the Public Health Service Act) is regulated by such State.

''(8) PARTICIPATING EMPLOYER.—The term 'participating employer' means, in connection with an association health plan, any employer, if any individual who is an employee of such employer, a partner in such employer, or a self-employed individual who is such employer (or any dependent, as defined under the terms of the plan, of such individual) is or was covered under such plan in connection with the status of such individual as such an employee, partner, or self-employed individual in relation to the plan.

''(9) APPLICABLE STATE AUTHORITY.—The term 'applicable State authority' means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of title XXVII of the Public Health Service Act for the State involved with respect to such issuer.

''(10) QUALIFIED ACTUARY.—The term 'qualified actuary' means an individual who is a member of the American Academy of Actuaries or meets such reasonable standards and qualifications as the Secretary may provide by regulation.

''(11) AFFILIATED MEMBER.—The term 'affiliated member' means, in connection with a sponsor, a person eligible to be a member of the sponsor or, in the case of a sponsor with member associations, a person who is a member, or is eligible to be a member, of a member association.

''(12) LARGE EMPLOYER.—The term 'large employer' means, in connection with a group health plan with respect to a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

''(13) SMALL EMPLOYER.—The term 'small employer' means, in connection with a group health plan with respect to a plan year, an employer who is not a large employer.

''(b) RULES OF CONSTRUCTION.—

''(1) EMPLOYERS AND EMPLOYEES.—For purposes of determining whether a plan, fund, or program is an employee welfare benefit plan which is an association health plan, and for purposes of applying this title in connection with such plan, fund, or program so determined to be such an employee welfare benefit plan—

"(A) in the case of a partnership, the term 'employer' (as defined in section (3)(5)) includes the partnership in relation to the partners, and the term 'employee' (as defined in section (3)(6)) includes any partner in relation to the partnership, and

"(B) in the case of a self-employed individual, the term 'employer' (as defined in section 3(5)) and the term 'employee' (as defined in section 3(6)) shall include such individual.

"(2) PLANS, FUNDS, AND PROGRAMS TREATED AS EMPLOYEE WELFARE BENEFIT PLANS.—In the case of any plan, fund, or program which was established or is maintained for the purpose of providing medical care (through the purchase of insurance or otherwise) for employees (or their dependents) covered thereunder and which demonstrates to the Secretary that all requirements for certification under this part would be met with respect to such plan, fund, or program if such plan, fund, or program were a group health plan, such plan, fund, or program shall be treated for purposes of this title as an employee welfare benefit plan on and after the date of such demonstration.".

(b) CONFORMING AMENDMENTS TO PREEMPTION RULES.—

(1) Section 514(b)(6) of such Act (29 U.S.C. 1144(b)(6)) is amended by adding at the end the following new subparagraph:

''(E) The preceding subparagraphs of this paragraph do not apply with respect to any State law in the case of an association health plan which is certified under part 8.''.

(2) Section 514 of such Act (29 U.S.C. 1144) is amended—

(A) in subsection (b)(4), by striking ''Subsection (a)'' and inserting ''Subsections (a) and (d)'';

(B) in subsection (b)(5), by striking ''subsection (a)'' in subparagraph (A) and inserting ''subsection (a) of this section and subsections (a)(2)(B) and (b) of section 805'', and by striking ''subsection (a)'' in subparagraph (B) and inserting ''subsection (a) of this section or subsection (a)(2)(B) or (b) of section 805'';

(C) by redesignating subsection (d) as subsection (e); and

(D) by inserting after subsection (c) the following new subsection:

''(d)(1) Except as provided in subsection (b)(4), the provisions of this title shall supersede any and all State laws insofar as they may now or hereafter preclude, or have the effect of precluding, a health insurance issuer from offering health insurance coverage in connection with an association health plan which is certified under part 8.

''(2) Except as provided in paragraphs (4) and (5) of subsection (b) of this section—

''(A) In any case in which health insurance coverage of any policy type is offered under an association health plan certified under part 8 to a participating employer operating in such State, the provisions of this title shall supersede any and all laws of such State insofar as they may preclude a health insurance issuer from offering health insurance coverage of the same policy type to other employers operating in the State which are eligible for coverage under such association health plan, whether or not such other employers are participating employers in such plan.

''(B) In any case in which health insurance coverage of any policy type is offered under an association health plan in a State and the filing, with the applicable State authority, of the policy form in con-

nection with such policy type is approved by such State authority, the provisions of this title shall supersede any and all laws of any other State in which health insurance coverage of such type is offered, insofar as they may preclude, upon the filing in the same form and manner of such policy form with the applicable State authority in such other State, the approval of the filing in such other State.

''(3) For additional provisions relating to association health plans, see subsections (a)(2)(B) and (b) of section 805.

''(4) For purposes of this subsection, the term 'association health plan' has the meaning provided in section 801(a), and the terms 'health insurance coverage', 'participating employer', and 'health insurance issuer' have the meanings provided such terms in section 811, respectively.''.

(3) Section 514(b)(6)(A) of such Act (29 U.S.C. 1144(b)(6)(A)) is amended—

(A) in clause (i)(II), by striking ''and'' at the end;

(B) in clause (ii), by inserting ''and which does not provide medical care (within the meaning of section 733(a)(2)),'' after ''arrange-

ment,'', and by striking ''title.'' and inserting ''title, and''; and

(C) by adding at the end the following new clause:

''(iii) subject to subparagraph (E), in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement and which provides medical care (within the meaning of section 733(a)(2)), any law of any State which regulates insurance may apply.''.

(4) Section 514(e) of such Act (as redesignated by paragraph (2)(C)) is amended—

(A) by striking ''Nothing'' and inserting ''(1) Except as provided in paragraph (2), nothing''; and

(B) by adding at the end the following new paragraph:

''(2) Nothing in any other provision of law enacted on or after the date of the enactment of the Patient Protection Act of 1998 shall be construed to alter, amend, modify, invalidate, impair, or supersede any provision of this title, except by specific cross-reference to the affected section.''.

(c) PLAN SPONSOR.—Section 3(16)(B) of such Act (29 U.S.C. 102(16)(B)) is amended by adding at the end

the following new sentence: ''Such term also includes a person serving as the sponsor of an association health plan under part 8.''.

(d) DISCLOSURE OF SOLVENCY PROTECTIONS RELATED TO SELF-INSURED AND FULLY INSURED OPTIONS UNDER ASSOCIATION HEALTH PLANS.—Section 102(b) of such Act (29 U.S.C. 102(b)) is amended by adding at the end the following: ''An association health plan shall include in its summary plan description, in connection with each benefit option, a description of the form of solvency or guarantee fund protection secured pursuant to this Act or applicable State law, if any.''.

(e) SAVINGS CLAUSE.—Section 731(c) of such Act is amended by inserting ''or part 8'' after ''this part''.

(f) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating to section 734 the following new items:

''PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

''Sec. 801. Association health plans.
''Sec. 802. Certification of association health plans.
''Sec. 803. Requirements relating to sponsors and boards of trustees.
''Sec. 804. Participation and coverage requirements.
''Sec. 805. Other requirements relating to plan documents, contribution rates, and benefit options.
''Sec. 806. Maintenance of reserves and provisions for solvency for plans providing health benefits in addition to health insurance coverage.
''Sec. 807. Requirements for application and related requirements.
''Sec. 808. Notice requirements for voluntary termination.
''Sec. 809. Corrective actions and mandatory termination.

SEC. 1303. CLARIFICATION OF TREATMENT OF SINGLE EMPLOYER ARRANGEMENTS.

Section 3(40)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(40)(B)) is amended—

(1) in clause (i), by inserting ''for any plan year of any such plan, or any fiscal year of any such other arrangement;'' after ''single employer'', and by inserting ''during such year or at any time during the preceding 1-year period'' after ''control group'';

(2) in clause (iii)—

(A) by striking ''common control shall not be based on an interest of less than 25 percent'' and inserting ''an interest of greater than 25 percent may not be required as the minimum interest necessary for common control''; and

(B) by striking ''similar to'' and inserting ''consistent and coextensive with'';

(3) by redesignating clauses (iv) and (v) as clauses (v) and (vi), respectively; and

(4) by inserting after clause (iii) the following new clause:

''(iv) in determining, after the application of clause (i), whether benefits are provided to employees of two or more employers, the arrangement shall be treated as having only 1 participating employer if, after the application of clause (i), the number of individuals who are employees and former employees of any one participating employer and who are covered under the arrangement is greater than 75 percent of the aggregate number of all individuals who are employees or former employees of participating employers and who are covered under the arrangement,''.

SEC. 1304. CLARIFICATION OF TREATMENT OF CERTAIN COLLECTIVELY BARGAINED ARRANGEMENTS.

(a) IN GENERAL.—Section 3(40)(A)(i) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(40)(A)(i)) is amended to read as follows:

''(i)(I) under or pursuant to one or more collective bargaining agreements which are reached pursuant to collective bargaining described in section 8(d) of the National Labor Relations Act (29 U.S.C. 158(d)) or paragraph Fourth of section 2 of the Railway Labor Act (45 U.S.C. 152, paragraph Fourth) or which are reached pursuant to labor-

management negotiations under similar provisions of State public employee relations laws, and (II) in accordance with subparagraphs (C), (D), and (E),''.

(b) LIMITATIONS.—Section 3(40) of such Act (29 U.S.C. 1002(40)) is amended by adding at the end the following new subparagraphs:

''(C) For purposes of subparagraph (A)(i)(II), a plan or other arrangement shall be treated as established or maintained in accordance with this subparagraph only if the following requirements are met:

''(i) The plan or other arrangement, and the employee organization or any other entity sponsoring the plan or other arrangement, do not—

''(I) utilize the services of any licensed insurance agent or broker for soliciting or enrolling employers or individuals as participating employers or covered individuals under the plan or other arrangement; or

''(II) pay a commission or any other type of compensation to a person, other than a full time employee of the employee organization (or a member of the organization to the extent provided in regulations of the Secretary), that is related either to the volume or number of employers or individuals solicited or enrolled as

participating employers or covered individuals under the plan or other arrangement, or to the dollar amount or size of the contributions made by participating employers or covered individuals to the plan or other arrangement;

except to the extent that the services used by the plan, arrangement, organization, or other entity consist solely of preparation of documents necessary for compliance with the reporting and disclosure requirements of part 1 or administrative, investment, or consulting services unrelated to solicitation or enrollment of covered individuals.

''(ii) As of the end of the preceding plan year, the number of covered individuals under the plan or other arrangement who are identified to the plan or arrangement and who are neither—

''(I) employed within a bargaining unit covered by any of the collective bargaining agreements with a participating employer (nor covered on the basis of an individual's employment in such a bargaining unit); nor

''(II) present employees (or former employees who were covered while employed) of the sponsoring employee organization, of an employer who is or was a party to any of the col-

lective bargaining agreements, or of the plan or other arrangement or a related plan or arrangement (nor covered on the basis of such present or former employment);

does not exceed 15 percent of the total number of individuals who are covered under the plan or arrangement and who are present or former employees who are or were covered under the plan or arrangement pursuant to a collective bargaining agreement with a participating employer. The requirements of the preceding provisions of this clause shall be treated as satisfied if, as of the end of the preceding plan year, such covered individuals are comprised solely of individuals who were covered individuals under the plan or other arrangement as of the date of the enactment of the Small Business Affordable Health Coverage Act of 1998 and, as of the end of the preceding plan year, the number of such covered individuals does not exceed 25 percent of the total number of present and former employees enrolled under the plan or other arrangement.

''(iii) The employee organization or other entity sponsoring the plan or other arrangement certifies to the Secretary each year, in a form and manner which shall be prescribed in regulations of the Sec-

retary that the plan or other arrangement meets the requirements of clauses (i) and (ii).

''(D) For purposes of subparagraph (A)(i)(II), a plan or arrangement shall be treated as established or maintained in accordance with this subparagraph only if—

''(i) all of the benefits provided under the plan or arrangement consist of health insurance coverage; or

''(ii)(I) the plan or arrangement is a multiemployer plan; and

''(II) the requirements of clause (B) of the proviso to clause (5) of section 302(c) of the Labor Management Relations Act, 1947 (29 U.S.C. 186(c)) are met with respect to such plan or other arrangement.

''(E) For purposes of subparagraph (A)(i)(II), a plan or arrangement shall be treated as established or maintained in accordance with this subparagraph only if—

''(i) the plan or arrangement is in effect as of the date of the enactment of the Small Business Affordable Health Coverage Act of 1998, or

''(ii) the employee organization or other entity sponsoring the plan or arrangement—

''(I) has been in existence for at least 3 years or is affiliated with another employee or-

ganization which has been in existence for at least 3 years, or

''(II) demonstrates to the satisfaction of the Secretary that the requirements of subparagraphs (C) and (D) are met with respect to the plan or other arrangement.''.

(c) CONFORMING AMENDMENTS TO DEFINITIONS OF PARTICIPANT AND BENEFICIARY.—Section 3(7) of such Act (29 U.S.C. 1002(7)) is amended by adding at the end the following new sentence: ''Such term includes an individual who is a covered individual described in paragraph (40)(C)(ii).''.

SEC. 1305. ENFORCEMENT PROVISIONS RELATING TO ASSOCIATION HEALTH PLANS.

(a) CRIMINAL PENALTIES FOR CERTAIN WILLFUL MISREPRESENTATIONS.—Section 501 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131) is amended—

(1) by inserting ''(a)'' after ''SEC. 501.''; and

(2) by adding at the end the following new subsection:

''(b) Any person who, either willfully or with willful blindness, falsely represents, to any employee, any employee's beneficiary, any employer, the Secretary, or any State, a plan or other arrangement established or maintained for

the purpose of offering or providing any benefit described in section 3(1) to employees or their beneficiaries as—

''(1) being an association health plan which has been certified under part 8;

''(2) having been established or maintained under or pursuant to one or more collective bargaining agreements which are reached pursuant to collective bargaining described in section 8(d) of the National Labor Relations Act (29 U.S.C. 158(d)) or paragraph Fourth of section 2 of the Railway Labor Act (45 U.S.C. 152, paragraph Fourth) or which are reached pursuant to labor-management negotiations under similar provisions of State public employee relations laws; or

''(3) being a plan or arrangement with respect to which the requirements of subparagraph (C), (D), or (E) of section 3(40) are met;

shall, upon conviction, be imprisoned not more than five years, be fined under title 18, United States Code, or both.''.

(b) CEASE ACTIVITIES ORDERS.—Section 502 of such Act (29 U.S.C. 1132) is amended by adding at the end the following new subsection:

''(n)(1) Subject to paragraph (2), upon application by the Secretary showing the operation, promotion, or

marketing of an association health plan (or similar arrangement providing benefits consisting of medical care (as defined in section 733(a)(2))) that—

''(A) is not certified under part 8, is subject under section 514(b)(6) to the insurance laws of any State in which the plan or arrangement offers or provides benefits, and is not licensed, registered, or otherwise approved under the insurance laws of such State; or

''(B) is an association health plan certified under part 8 and is not operating in accordance with the requirements under part 8 for such certification,

a district court of the United States shall enter an order requiring that the plan or arrangement cease activities.

''(2) Paragraph (1) shall not apply in the case of an association health plan or other arrangement if the plan or arrangement shows that—

''(A) all benefits under it referred to in paragraph (1) consist of health insurance coverage; and

''(B) with respect to each State in which the plan or arrangement offers or provides benefits, the plan or arrangement is operating in accordance with applicable State laws that are not superseded under section 514.

''(3) The court may grant such additional equitable relief, including any relief available under this title, as it deems necessary to protect the interests of the public and of persons having claims for benefits against the plan.''.

(c) RESPONSIBILITY FOR CLAIMS PROCEDURE.—Section 503 of such Act (29 U.S.C. 1133) (as amended by title I) is amended by adding at the end the following new subsection:

''(c) ASSOCIATION HEALTH PLANS.—The terms of each association health plan which is or has been certified under part 8 shall require the board of trustees or the named fiduciary (as applicable) to ensure that the requirements of this section are met in connection with claims filed under the plan.''.

SEC. 1306. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

Section 506 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1136) is amended by adding at the end the following new subsection:

''(c) RESPONSIBILITY OF STATES WITH RESPECT TO ASSOCIATION HEALTH PLANS.—

''(1) AGREEMENTS WITH STATES.—A State may enter into an agreement with the Secretary for delegation to the State of some or all of—

''(A) the Secretary's authority under sections 502 and 504 to enforce the requirements for certification under part 8,

''(B) the Secretary's authority to certify association health plans under part 8 in accordance with regulations of the Secretary applicable to certification under part 8, or

''(C) any combination of the Secretary's authority authorized to be delegated under subparagraphs (A) and (B).

''(2) DELEGATIONS.—Any department, agency, or instrumentality of a State to which authority is delegated pursuant to an agreement entered into under this paragraph may, if authorized under State law and to the extent consistent with such agreement, exercise the powers of the Secretary under this title which relate to such authority.

''(3) RECOGNITION OF PRIMARY DOMICILE STATE.—In entering into any agreement with a State under subparagraph (A), the Secretary shall ensure that, as a result of such agreement and all other agreements entered into under subparagraph (A), only one State will be recognized, with respect to any particular association health plan, as the State to which all authority has been delegated pur-

suant to such agreements in connection with such plan. In carrying out this paragraph, the Secretary shall take into account the places of residence of the participants and beneficiaries under the plan and the State in which the trust is maintained.''.

SEC. 1307. EFFECTIVE DATE AND TRANSITIONAL AND OTHER RULES.

(a) EFFECTIVE DATE.—The amendments made by sections 1302, 1305, and 1306 shall take effect on January 1, 2000. The amendments made by sections 1303 and 1304 shall take effect on the date of the enactment of this Act. The Secretary of Labor shall first issue all regulations necessary to carry out the amendments made by this Act before January 1, 2000.

(b) EXCEPTION.—Section 801(a)(2) of the Employee Retirement Income Security Act of 1974 (added by section 1302) does not apply in connection with an association health plan (certified under part 8 of subtitle B of title I of such Act) existing on April 1, 1997, if no benefits provided thereunder as of the date of the enactment of this Act consist of health insurance coverage (as defined in section 733(b)(1) of such Act).

(c) TREATMENT OF CERTAIN EXISTING HEALTH BENEFITS PROGRAMS.—

(1) IN GENERAL.—In any case in which, as of the date of the enactment of this Act, an arrangement is maintained in a State for the purpose of providing benefits consisting of medical care for the employees and beneficiaries of its participating employers, at least 200 participating employers make contributions to such arrangement, such arrangement has been in existence for at least 10 years, and such arrangement is licensed under the laws of one or more States to provide such benefits to its participating employers, upon the filing with the applicable authority (as defined in section 813(a)(5) of the Employee Retirement Income Security Act of 1974 (as amended by this Act)) by the arrangement of an application for certification of the arrangement under part 8 of subtitle B of title I of such Act—

(A) such arrangement shall be deemed to be a group health plan for purposes of title I of such Act,

(B) the requirements of sections 801(a)(1) and 803(a)(1) of the Employee Retirement Income Security Act of 1974 shall be deemed met with respect to such arrangement,

(C) the requirements of section 803(b) of such Act shall be deemed met, if the arrange-

ment is operated by a board of directors which—

(i) is elected by the participating employers, with each employer having one vote, and

(ii) has complete fiscal control over the arrangement and which is responsible for all operations of the arrangement,

(D) the requirements of section 804(a) of such Act shall be deemed met with respect to such arrangement,

(E) the arrangement may be certified by any applicable authority with respect to its operations in any State only if it operates in such State on the date of certification.

The provisions of this subsection shall cease to apply with respect to any such arrangement at such time after the date of the enactment of this Act as the applicable requirements of this subsection are not met with respect to such arrangement.

(2) DEFINITIONS.—For purposes of this subsection, the terms ''group health plan,'' ''medical care,'' and ''participating employer'' shall have the meanings provided in section 813 of the Employee Retirement Income Security Act of 1974, except

that the reference in paragraph (7) of such section to an ''association health plan'' shall be deemed a reference to an arrangement referred to in this subsection.

(d) PILOT PROGRAM FOR SELF-INSURED ASSOCIATION HEALTH PLANS.—

(1) IN GENERAL.—During the pilot program period, association health plans which offer benefit options which do not consist of health insurance coverage may be certified under part 8 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 only if such plans consist of the following:

(A) plans which offered such coverage on the date of the enactment of this Act,

(B) plans under which the sponsor does not restrict membership to one or more trades and businesses or industries and whose eligible participating employers represent a broad cross-section of trades and businesses or industries, or

(C) plans whose eligible participating employers represent one or more trades or businesses, or one or more industries, which have been indicated as having average or above-aver-

age health insurance risk or health claims experience by reason of State rate filings, denials of coverage, proposed premium rate levels, and other means demonstrated by such plans in accordance with regulations which the Secretary shall prescribe, including (but not limited to) the following: agriculture; automobile dealerships; barbering and cosmetology; child care; construction; dance, theatrical, and orchestra productions; disinfecting and pest control; eating and drinking establishments; fishing; hospitals; labor organizations; logging; manufacturing (metals); mining; medical and dental practices; medical laboratories; sanitary services; transportation (local and freight); and warehousing.

(2) PILOT PROGRAM PERIOD.—For purposes of this subsection, the term ''pilot program period'' means the 5-year period beginning on January 1, 1999.

TITLE II—AMENDMENTS TO PUBLIC HEALTH SERVICE ACT

Subtitle A—Patient Protections and Point of Service Coverage Requirements

SEC. 2001. PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE, EMERGENCY MEDICAL CARE, OBSTETRIC AND GYNECOLOGICAL CARE, PEDIATRIC CARE.

(a) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act is amended by adding at the end the following new section:

"SEC. 2706. PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE, EMERGENCY MEDICAL CARE, OBSTETRIC AND GYNECOLOGICAL CARE, PEDIATRIC CARE.

''(a) PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE.—

''(1) IN GENERAL.—In the case of any health care professional acting within the lawful scope of practice in the course of carrying out a contractual employment arrangement or other direct contractual arrangement between such professional and a group health plan or a health insurance issuer offering health insurance coverage in connection with a group

health plan, the plan or issuer with which such contractual employment arrangement or other direct contractual arrangement is maintained by the professional may not impose on such professional under such arrangement any prohibition with respect to advice, provided to a participant or beneficiary under the plan who is a patient, about the health status of the participant or beneficiary or the medical care or treatment for the condition or disease of the participant or beneficiary, regardless of whether benefits for such care or treatment are provided under the plan or health insurance coverage offered in connection with the plan.

''(2) HEALTH CARE PROFESSIONAL DEFINED.—For purposes of this subsection, the term 'health care professional' means a physician (as defined in section 1861(r) of the Social Security Act) or other health care professional if coverage for the professional's services is provided under the group health plan for the services of the professional. Such term includes a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist and therapy assistant, speech–language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner,

clinical nurse specialist, certified registered nurse anesthetist, and certified nurse–midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

"(b) PATIENT ACCESS TO EMERGENCY MEDICAL CARE.—

"(1) IN GENERAL.—To the extent that the group health plan (or health insurance issuer offering health insurance coverage in connection with the plan) provides for any benefits consisting of emergency medical care (as defined in section 503(b)(9)(I) of the Employee Retirement Income Security Act of 1974), except for items or services specifically excluded—

"(A) the plan or issuer shall provide benefits, without requiring preauthorization, for appropriate emergency medical screening examinations (within the capability of the emergency facility, including ancillary services routinely available to the emergency facility) to the extent that a prudent layperson, who possesses an average knowledge of health and medicine, would determine such examinations to be necessary in order to determine whether emergency medical care (as so defined) is required, and

"(B) the plan or issuer shall provide benefits for additional emergency medical services following an emergency medical screening examination (if determined necessary under subparagraph (A)) to the extent that a prudent emergency medical professional would determine such additional emergency services to be necessary to avoid the consequences described in section 503(b)(9)(I) of such Act.

"(2) UNIFORM COST-SHARING REQUIRED.—Nothing in this subsection shall be construed as preventing a group health plan or issuer from imposing any form of cost-sharing applicable to any participant or beneficiary (including coinsurance, copayments, deductibles, and any other charges) in relation to benefits described in paragraph (1), if such form of cost-sharing is uniformly applied under such plan, with respect to similarly situated participants and beneficiaries, to all benefits consisting of emergency medical care (as defined in section 503(b)(9)(I) of the Employee Retirement Income Security Act of 1974) provided to such similarly situated participants and beneficiaries under the plan.

"(c) PATIENT ACCESS TO OBSTETRIC AND GYNECOLOGICAL CARE.

''(1) IN GENERAL.—In any case in which a group health plan (or a health insurance issuer offering health insurance coverage in connection with the plan)—

''(A) provides benefits under the terms of the plan consisting of—

''(i) routine gynecological care (such as preventive women's health examinations), or

''(ii) routine obstetric care (such as routine pregnancy-related services),

provided by a participating physician who specializes in such care (or provides benefits consisting of payment for such care), and

''(B) the plan requires or provides for designation by a participant or beneficiary of a participating primary care provider,

if the primary care provider designated by such a participant or beneficiary is not such a physician, then the plan (or issuer) shall meet the requirements of paragraph (2).

''(2) REQUIREMENTS.—A group health plan (or a health insurance issuer offering health insurance coverage in connection with the plan) meets the requirements of this paragraph, in connection with

benefits described in paragraph (1) consisting of care described in clause (i) or (ii) of paragraph (1)(A) (or consisting of payment therefor), if the plan (or issuer)—

"(A) does not require authorization or a referral by the primary care provider in order to obtain such benefits, and

"(B) treats the ordering of other routine care of the same type, by the participating physician providing the care described in clause (i) or (ii) of paragraph (1)(A), as the authorization of the primary care provider with respect to such care.

"(3) CONSTRUCTION.—Nothing in paragraph (2)(B) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of gynecological or obstetric care so ordered.

"(d) PATIENT ACCESS TO PEDIATRIC CARE.—

"(1) IN GENERAL.—In any case in which a group health plan (or a health insurance issuer offering health insurance coverage in connection with the plan) provides benefits consisting of routine pediatric care provided by a participating physician who specializes in pediatrics (or consisting of pay-

ment for such care) and the plan requires or provides for designation by a participant or beneficiary of a participating primary care provider, the plan (or issuer) shall provide that such a participating physician may be designated, if available, by a parent or guardian of any beneficiary under the plan is who under 18 years of age, as the primary care provider with respect to any such benefits.

''(2) CONSTRUCTION.—Nothing in paragraph (1) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of pediatric care.

''(e) TREATMENT OF MULTIPLE COVERAGE OPTIONS.—In the case of a plan providing benefits under two or more coverage options, the requirements of subsections (c) and (d) shall apply separately with respect to each coverage option.''.

(c) EFFECTIVE DATE AND RELATED RULES.—

(1) IN GENERAL.—The amendments made by this section shall apply with respect to plan years beginning on or after January 1 of the second calendar year following the date of the enactment of this Act, except that the Secretary of Health and Human Services may issue regulations before such date under such amendments. The Secretary shall

first issue all regulations necessary to carry out the amendments made by this section before the effective date thereof.

(2) LIMITATION ON ENFORCEMENT ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this section, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by such amendments before the date of issuance of regulations issued in connection with such requirement, if the plan or issuer has sought to comply in good faith with such requirement.

(3) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the amendments made by this section shall not apply with respect to plan years beginning before the later of—

(1) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

(2) January 1, 2001.

For purposes of this paragraph, any plan amendments made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this section shall not be treated as a termination of such collective bargaining agreement.

SEC. 2002. REQUIRING HEALTH MAINTENANCE ORGANIZATIONS TO OFFER OPTION OF POINT-OF-SERVICE COVERAGE.

(a) IN GENERAL.—Title XXVII of the Public Health Service Act is amended by inserting after section 2713 the following new section:

"SEC. 2714. REQUIRING OFFERING OF OPTION OF POINT-OF-SERVICE COVERAGE.

''(a) REQUIREMENT TO OFFER COVERAGE OPTION TO CERTAIN EMPLOYERS.—Except as provided in subsection (c), any health insurance issuer which—

''(1) is a health maintenance organization (as defined in section 2791(b)(3)), and

''(2) which provides for coverage of services of one or more classes of health care professionals under health insurance coverage offered in connection with a group health plan only if such services are furnished exclusively through health care profes-

sionals within such class or classes who are members of a closed panel of health care professionals,

the issuer shall make available to the plan sponsor in connection with such a plan a coverage option which provides for coverage of such services which are furnished through such class (or classes) of health care professionals regardless of whether or not the professionals are members of such panel.

''(b) REQUIREMENT TO OFFER SUPPLEMENTAL COVERAGE TO PARTICIPANTS IN CERTAIN CASES.—Except as provided in subsection (c), if a health insurance issuer makes available a coverage option under and described in subsection (a) to a plan sponsor of a group health plan and the sponsor declines to contract for such coverage option, then the issuer shall make available in the individual insurance market to each participant in the group health plan optional separate supplemental health insurance coverage in the individual health insurance market which consists of services identical to those provided under such coverage provided through the closed panel under the group health plan but are furnished exclusively by health care professionals who are not members of such a closed panel.

''(c) EXCEPTIONS.—

''(1) OFFERING OF NON-PANEL OPTION.—Subsections (a) and (b) shall not apply with respect to

a group health plan if the plan offers a coverage option that provides coverage for services that may be furnished by a class or classes of health care professionals who are not in a closed panel. This paragraph shall be applied separately to distinguishable groups of employees under the plan.

''(2) AVAILABILITY OF COVERAGE THROUGH HEALTHMART.—Subsections (a) and (b) shall not apply to a group health plan if the health insurance coverage under the plan is made available through a HealthMart (as defined in section 2801) and if any health insurance coverage made available through the HealthMart provides for coverage of the services of any class of health care professionals other than through a closed panel of professionals.

''(3) RELICENSURE EXEMPTION.—Subsections (a) and (b) shall not apply to a health maintenance organization in a State in any case in which—

''(A) the organization demonstrates to the applicable authority that the organization has made a good faith effort to obtain (but has failed to obtain) a contract between the organization and any other health insurance issuer providing for the coverage option or supplemental coverage described in subsection (a) or

(b), as the case may be, within the applicable service area of the organization, and

''(B) the State requires the organization to receive or qualify for a separate license, as an indemnity insurer or otherwise, in order to offer such coverage option or supplemental coverage, respectively.

The applicable authority may require that the organization demonstrate that it meets the requirements of the previous sentence no more frequently that once every two years.

''(4) INCREASED COSTS.—Subsections (a) and (b) shall not apply to a health maintenance organization if the organization demonstrates to the applicable authority, in accordance with generally accepted actuarial practice, that, on either a prospective or retroactive basis, the premium for the coverage option or supplemental coverage required to be made available under such respective subsection exceeds by more than 1 percent the premium for the coverage consisting of services which are furnished through a closed panel of health care professionals in the class or classes involved. The applicable authority may require that the organization demonstrate such an increase no more frequently that once every two years.

This paragraph shall be applied on an average per enrollee or similar basis.

''(5) COLLECTIVE BARGAINING AGREEMENTS.—Subsections (a) and (b) shall not apply in connection with a group health plan if the plan is established or maintained pursuant to one or more collective bargaining agreements.

''(d) DEFINITIONS.—For purposes of this section:

''(1) COVERAGE THROUGH CLOSED PANEL.—Health insurance coverage for a class of health care professionals shall be treated as provided through a closed panel of such professionals only if such coverage consists of coverage of items or services consisting of professionals services which are reimbursed for or provided only within a limited network of such professionals.

''(2) HEALTH CARE PROFESSIONAL.—The term 'health care professional' has the meaning given such term in section 2706(a)(2).''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to coverage offered on or after January 1 of the second calendar year following the date of the enactment of this Act.

Subtitle B—Patient Access to Information

SEC. 2101. PATIENT ACCESS TO INFORMATION REGARDING PLAN COVERAGE, MANAGED CARE PROCEDURES, HEALTH CARE PROVIDERS, AND QUALITY OF MEDICAL CARE.

(a) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act (as amended by subtitle A of this title) is amended further by adding at the end the following new section:

"SEC. 2707. PATIENT ACCESS TO INFORMATION REGARDING PLAN COVERAGE, MANAGED CARE PROCEDURES, HEALTH CARE PROVIDERS, AND QUALITY OF MEDICAL CARE.

''(a) DISCLOSURE REQUIREMENT.—Each health insurance issuer offering health insurance coverage in connection with a group health plan shall provide the administrator of such plan on a timely basis with the information necessary to enable the administrator to include in the summary plan description of the plan required under section 102 of the Employee Retirement Income Security Act of 1974 (or each summary plan description in any case in which different summary plan descriptions are appropriate under part 1 of subtitle B of title I of such Act for different options of coverage) the information required

under subsections (b), (c), (d), and (e)(2)(A). To the extent that any such issuer provides such information on a timely basis to plan participants and beneficiaries, the requirements of this subsection shall be deemed satisfied in the case of such plan with respect to such information.

''(b) PLAN BENEFITS.—The information required under subsection (a) includes the following:

''(1) COVERED ITEMS AND SERVICES.—

''(A) CATEGORIZATION OF INCLUDED BENEFITS.—A description of covered benefits, categorized by—

''(i) types of items and services (including any special disease management program), and

''(ii) types of health care professionals providing such items and services.

''(B) EMERGENCY MEDICAL CARE.—A description of the extent to which the coverage includes emergency medical care (including the extent to which the coverage provides for access to urgent care centers), and any definitions provided under in connection with such coverage for the relevant coverage terminology referring to such care.

"(C) PREVENTATIVE SERVICES.—A description of the extent to which the coverage includes benefits for preventative services.

"(D) DRUG FORMULARIES.—A description of the extent to which covered benefits are determined by the use or application of a drug formulary and a summary of the process for determining what is included in such formulary.

"(E) COBRA CONTINUATION COVERAGE.—A description of the benefits available under the coverage provided pursuant to part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974.

"(2) LIMITATIONS, EXCLUSIONS, AND RESTRICTIONS ON COVERED BENEFITS.—

"(A) CATEGORIZATION OF EXCLUDED BENEFITS.—A description of benefits specifically excluded from coverage, categorized by types of items and services.

"(B) UTILIZATION REVIEW AND PREAUTHORIZATION REQUIREMENTS.—Whether coverage for medical care is limited or excluded on the basis of utilization review or preauthorization requirements.

"(C) LIFETIME, ANNUAL, OR OTHER PERIOD LIMITATIONS.—A description of the circumstances under which, and the extent to which, coverage is subject to lifetime, annual, or other period limitations, categorized by types of benefits.

"(D) CUSTODIAL CARE.—A description of the circumstances under which, and the extent to which, the coverage of benefits for custodial care is limited or excluded, and a statement of the definition used in connection with such coverage for custodial care.

"(E) EXPERIMENTAL TREATMENTS.—Whether coverage for any medical care is limited or excluded because it constitutes experimental treatment or technology, and any definitions provided in connection with such coverage for the relevant plan terminology referring to such limited or excluded care.

"(F) MEDICAL APPROPRIATENESS OR NECESSITY.—Whether coverage for medical care may be limited or excluded by reason of a failure to meet the plan's requirements for medical appropriateness or necessity, and any definitions provided in connection with such coverage

for the relevant coverage terminology referring to such limited or excluded care.

"(G) SECOND OR SUBSEQUENT OPINIONS.—A description of the circumstances under which, and the extent to which, coverage for second or subsequent opinions is limited or excluded.

"(H) SPECIALTY CARE.—A description of the circumstances under which, and the extent to which, coverage of benefits for specialty care is conditioned on referral from a primary care provider.

"(I) CONTINUITY OF CARE.—A description of the circumstances under which, and the extent to which, coverage of items and services provided by any health care professional is limited or excluded by reason of the departure by the professional from any defined set of providers.

"(J) RESTRICTIONS ON COVERAGE OF EMERGENCY SERVICES.—A description of the circumstances under which, and the extent to which, the coverage, in including emergency medical care furnished to a participant or beneficiary of the plan imposes any financial respon-

sibility described in subsection (c) on participants or beneficiaries or limits or conditions benefits for such care subject to any other term or condition of such coverage.

''(c) PARTICIPANT'S FINANCIAL RESPONSIBILITIES.—The information required under subsection (a) includes an explanation of—

''(1) a participant's financial responsibility for payment of premiums, coinsurance, copayments, deductibles, and any other charges, and

''(2) the circumstances under which, and the extent to which, the participant's financial responsibility described in paragraph (1) may vary, including any distinctions based on whether a health care provider from whom covered benefits are obtained is included in a defined set of providers.

''(d) DISPUTE RESOLUTION PROCEDURES.—The information required under subsection (a) includes a description of the processes adopted in connection with such coverage pursuant to section 503(b) of the Employee Retirement Income Security Act of 1974, including—

''(1) descriptions thereof relating specifically to—

''(A) coverage decisions,

''(B) internal review of coverage decisions, and

''(C) any external review of coverage decisions, and

''(2) the procedures and time frames applicable to each step of the processes referred to in subparagraphs (A), (B), and (C) of paragraph (1).

''(e) INFORMATION AVAILABLE ON REQUEST.—

''(1) ACCESS TO PLAN BENEFIT INFORMATION IN ELECTRONIC FORM.—

''(A) IN GENERAL.—A group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) shall, upon written request (made not more frequently than annually), make available to participants and beneficiaries, in a generally recognized electronic format, the following information:

''(i) the latest summary plan description, including the latest summary of material modifications, and

''(ii) the actual plan provisions setting forth the benefits available under the plan, to the extent such information relates to the coverage options under the plan available to the

participant or beneficiary. A reasonable charge may be made to cover the cost of providing such information in such generally recognized electronic format. The Secretary may by regulation prescribe a maximum amount which will constitute a reasonable charge under the preceding sentence.

''(B) ALTERNATIVE ACCESS.—The requirements of this paragraph may be met by making such information generally available (rather than upon request) on the Internet or on a proprietary computer network in a format which is readily accessible to participants and beneficiaries.

''(2) ADDITIONAL INFORMATION TO BE PROVIDED ON REQUEST.—

''(A) INCLUSION IN SUMMARY PLAN DESCRIPTION OF SUMMARY OF ADDITIONAL INFORMATION.—The information required under subsection (a) includes a summary description of the types of information required by this subsection to be made available to participants and beneficiaries on request.

''(B) INFORMATION REQUIRED FROM PLANS AND ISSUERS ON REQUEST.—In addition

to information required to be included in summary plan descriptions under this subsection, a group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) shall provide the following information to a participant or beneficiary on request:

''(i) NETWORK CHARACTERISTICS.—If the plan (or issuer) utilizes a defined set of providers under contract with the plan (or issuer), a detailed list of the names of such providers and their geographic location, set forth separately with respect to primary care providers and with respect to specialists.

''(ii) CARE MANAGEMENT INFORMATION.—A description of the circumstances under which, and the extent to which, the plan has special disease management programs or programs for persons with disabilities, indicating whether these programs are voluntary or mandatory and whether a significant benefit differential results from participation in such programs.

''(iii) INCLUSION OF DRUGS AND BIOLOGICALS IN FORMULARIES.—A statement of whether a specific drug or biological is included in a formulary used to determine benefits under the plan and a description of the procedures for considering requests for any patient-specific waivers.

''(iv) PROCEDURES FOR DETERMINING EXCLUSIONS BASED ON MEDICAL NECESSITY OR EXPERIMENTAL TREATMENTS.—Upon receipt by the participant or beneficiary of any notification of an adverse coverage decision based on a determination relating to medical necessity or an experimental treatment or technology, a description of the procedures and medically-based criteria used in such decision.

''(v) PREAUTHORIZATION AND UTILIZATION REVIEW PROCEDURES.—Upon receipt by the participant or beneficiary of any notification of an adverse coverage decision, a description of the basis on which any preauthorization requirement or any utilization review requirement has resulted in such decision.

''(vi) ACCREDITATION STATUS OF HEALTH INSURANCE ISSUERS AND SERVICE PROVIDERS.—A description of the accreditation and licencing status (if any) of each health insurance issuer offering health insurance coverage in connection with the plan and of any utilization review organization utilized by the issuer or the plan, together with the name and address of the accrediting or licencing authority.

''(vii) MEASURES OF ENROLLEE SATISFACTION.—The latest information (if any) maintained by the plan, or by any health insurance issuer offering health insurance coverage in connection with the plan, relating to enrollee satisfaction.

''(viii) QUALITY PERFORMANCE MEASURES.—The latest information (if any) maintained by the plan, or by any health insurance issuer offering health insurance coverage in connection with the plan, relating to quality of performance of the delivery of medical care with respect to coverage options offered under the plan and

of health care professionals and facilities providing medical care under the plan.

"(C) INFORMATION REQUIRED FROM HEALTH CARE PROFESSIONALS ON REQUEST.—Any health care professional treating a participant or beneficiary under a group health plan shall provide to the participant or beneficiary, on request, a description of his or her professional qualifications (including board certification status, licensing status, and accreditation status, if any), privileges, and experience and a general description by category (including salary, fee-for-service, capitation, and such other categories as may be specified in regulations of the Secretary) of the applicable method by which such professional is compensated in connection with the provision of such medical care.

"(D) INFORMATION REQUIRED FROM HEALTH CARE FACILITIES ON REQUEST.—Any health care facility from which a participant or beneficiary has sought treatment under a group health plan shall provide to the participant or beneficiary, on request, a description of the facility's corporate form or other organizational form and all forms of licensing and accredita-

tion status (if any) assigned to the facility by standard-setting organizations.

''(f) ACCESS TO INFORMATION RELEVANT TO THE COVERAGE OPTIONS UNDER WHICH THE PARTICIPANT OR BENEFICIARY IS ELIGIBLE TO ENROLL.—In addition to information otherwise required to be made available under this section, a group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) shall, upon written request (made not more frequently than annually), make available to a participant in connection with a period of enrollment the summary plan description for any coverage option under the plan under which the participant is eligible to enroll and any information described in clauses (i), (ii), (iii), (vi), (vii), and (viii) of subsection (e)(2)(B).

''(g) ADVANCE NOTICE OF CHANGES IN DRUG FORMULARIES.—Not later than 30 days before the effective of date of any exclusion of a specific drug or biological from any drug formulary under the plan that is used in the treatment of a chronic illness or disease, the plan shall take such actions as are necessary to reasonably ensure that plan participants are informed of such exclusion. The requirements of this subsection may be satisfied—

''(1) by inclusion of information in publications broadly distributed by plan sponsors, employers, or employee organizations,

''(2) by electronic means of communication (including the Internet or proprietary computer networks in a format which is readily accessible to participants),

''(3) by timely informing participants who, under an ongoing program maintained under the plan, have submitted their names for such notification, or

''(4) by any other reasonable means of timely informing plan participants.''.

SEC. 2102. REPORTING ON FRAUD AND ABUSE ENFORCEMENT ACTIVITIES.

The General Accounting Office shall—

(1) monitor—

(A) the compliance of the Department of Justice and all United States Attorneys–with the guideline entitled ''Guidance on the Use of the False Claims Act in Civil Health Care Matters'' issued by the Department on June 3, 1998, including any revisions to such guideline, and

(B) the compliance of the Office of the Inspector General of the Department of Health and Human Services with the protocols and guidelines entitled ''National Project Protocols—Best Practice Guidelines'' issued by the Inspector General on June 3, 1998, including any revisions to such protocols and guidelines, and

(2) submit a report on such compliance to the Committee on Commerce of the House of Representatives not later than February 1, 1999, and every year thereafter for a period of four years ending February 1, 2002.

SEC. 2103. EFFECTIVE DATE.

(a) IN GENERAL.—The amendments made by this subtitle shall apply with respect to plan years beginning on or after January 1 of the second calendar year following the date of the enactment of this Act. The Secretary shall first issue all regulations necessary to carry out the amendments made by this subtitle before such date.

(b) LIMITATION ON ENFORCEMENT ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this subtitle, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by such amendments before the

date of issuance of final regulations issued in connection with such requirement, if the plan or issuer has sought to comply in good faith with such requirement.

Subtitle C—HealthMarts

SEC. 2201. SHORT TITLE OF SUBTITLE.

This subtitle may be cited as the ''Health Care Consumer Empowerment Act of 1998''.

SEC. 2202. EXPANSION OF CONSUMER CHOICE THROUGH HEALTHMARTS.

The Public Health Service Act is amended by adding at the end the following new title:

''TITLE XXVIII—HEALTHMARTS

''SEC. 2801. DEFINITION OF HEALTHMART.

''(a) IN GENERAL.—For purposes of this title, the term 'HealthMart' means a legal entity that meets the following requirements:

''(1) ORGANIZATION.—The HealthMart is a nonprofit organization operated under the direction of a board of directors which is composed of representatives of not fewer than 2 and in equal numbers from each of the following:

''(A) Small employers.

''(B) Employees of small employers.

''(C) Health care providers, which may be physicians, other health care professionals,

health care facilities, or any combination thereof.

''(D) Entities, such as insurance companies, health maintenance organizations, and licensed provider-sponsored organizations, that underwrite or administer health benefits coverage.

''(2) OFFERING HEALTH BENEFITS COVERAGE.—

''(A) IN GENERAL.—The HealthMart, in conjunction with those health insurance issuers that offer health benefits coverage through the HealthMart, makes available health benefits coverage in the manner described in subsection (b) to all small employers and eligible employees in the manner described in subsection (c)(2) at rates (including employer's and employee's share) that are established by the health insurance issuer on a policy or product specific basis and that may vary only as permissible under State law. A HealthMart is deemed to be a group health plan for purposes of applying section 702 of the Employee Retirement Income Security Act of 1974, section 2702 of this Act, and section 9802(b) of the Internal Revenue

Code of 1986 (which limit variation among similarly situated individuals of required premiums for health benefits coverage on the basis of health status-related factors).

"(B) NONDISCRIMINATION IN COVERAGE OFFERED.—

"(i) IN GENERAL.—Subject to clause (ii), the HealthMart may not offer health benefits coverage to an eligible employee in a geographic area (as specified under paragraph (3)(A)) unless the same coverage is offered to all such employees in the same geographic area. Section 2711(a)(1)(B) of this Act limits denial of enrollment of certain eligible individuals under health benefits coverage in the small group market.

"(ii) CONSTRUCTION.—Nothing in this title shall be construed as requiring or permitting a health insurance issuer to provide coverage outside the service area of the issuer, as approved under State law.

"(C) NO FINANCIAL UNDERWRITING.—The HealthMart provides health benefits coverage only through contracts with health insurance

issuers and does not assume insurance risk with respect to such coverage.

(D) MINIMUM COVERAGE.—By the end of the first year of its operation and thereafter, the HealthMart maintains not fewer than 10 purchasers and 100 members.

''(3) GEOGRAPHIC AREAS.—

''(A) SPECIFICATION OF GEOGRAPHIC AREAS.—The HealthMart shall specify the geographic area (or areas) in which it makes available health benefits coverage offered by health insurance issuers to small employers. Such an area shall encompass at least one entire county or equivalent area.

''(B) MULTISTATE AREAS.—In the case of a HealthMart that serves more than one State, such geographic areas may be areas that include portions of two or more contiguous States.

''(C) MULTIPLE HEALTHMARTS PERMITTED IN SINGLE GEOGRAPHIC AREA.—Nothing in this title shall be construed as preventing the establishment and operation of more than one HealthMart in a geographic area or as lim-

iting the number of HealthMarts that may operate in any area.

''(4) PROVISION OF ADMINISTRATIVE SERVICES TO PURCHASERS.—

''(A) IN GENERAL.—The HealthMart provides administrative services for purchasers. Such services may include accounting, billing, enrollment information, and employee coverage status reports.

''(B) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing a HealthMart from serving as an administrative service organization to any entity.

''(5) DISSEMINATION OF INFORMATION.—The HealthMart collects and disseminates (or arranges for the collection and dissemination of) consumer-oriented information on the scope, cost, and enrollee satisfaction of all coverage options offered through the HealthMart to its members and eligible individuals. Such information shall be defined by the HealthMart and shall be in a manner appropriate to the type of coverage offered. To the extent practicable, such information shall include information on provider performance, locations and hours of operation of providers, outcomes, and similar matters.

Nothing in this section shall be construed as preventing the dissemination of such information or other information by the HealthMart or by health insurance issuers through electronic or other means.

''(6) FILING INFORMATION.—The HealthMart—

''(A) files with the applicable Federal authority information that demonstrates the HealthMart's compliance with the applicable requirements of this title; or

''(B) in accordance with rules established under section 2803(a), files with a State such information as the State may require to demonstrate such compliance.

''(b) HEALTH BENEFITS COVERAGE REQUIREMENTS.—

''(1) COMPLIANCE WITH CONSUMER PROTECTION REQUIREMENTS.—Any health benefits coverage offered through a HealthMart shall—

''(A) be underwritten by a health insurance issuer that—

''(i) is licensed (or otherwise regulated) under State law (or is a community health organization that is offering health

insurance coverage pursuant to section 330B(a)),

''(ii) meets all applicable State standards relating to consumer protection, subject to section 2802(b), and

''(iii) offers the coverage under a contract with the HealthMart;

''(B) subject to paragraph (2), be approved or otherwise permitted to be offered under State law; and

''(C) provide full portability of creditable coverage for individuals who remain members of the same HealthMart notwithstanding that they change the employer through which they are members in accordance with the provisions of the parts 6 and 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 and titles XXII and XXVII of this Act, so long as both employers are purchasers in the HealthMart.

''(2) ALTERNATIVE PROCESS FOR APPROVAL OF HEALTH BENEFITS COVERAGE IN CASE OF DISCRIMINATION OR DELAY.—

''(A) IN GENERAL.—The requirement of paragraph (1)(B) shall not apply to a policy or

product of health benefits coverage offered in a State if the health insurance issuer seeking to offer such policy or product files an application to waive such requirement with the applicable Federal authority, and the authority determines, based on the application and other evidence presented to the authority, that—

''(i) either (or both) of the grounds described in subparagraph (B) for approval of the application has been met; and

''(ii) the coverage meets the applicable State standards (other than those that have been preempted under section 2802).

''(B) GROUNDS.—The grounds described in this subparagraph with respect to a policy or product of health benefits coverage are as follows:

''(i) FAILURE TO ACT ON POLICY, PRODUCT, OR RATE APPLICATION ON A TIMELY BASIS.—The State has failed to complete action on the policy or product (or rates for the policy or product) within 90 days of the date of the State's receipt of a substantially complete application. No period before the date of the enactment of

this section shall be included in determining such 90-day period.

"(ii) DENIAL OF APPLICATION BASED ON DISCRIMINATORY TREATMENT.—The State has denied such an application and—

"(I) the standards or review process imposed by the State as a condition of approval of the policy or product imposes either any material requirements, procedures, or standards to such policy or product that are not generally applicable to other policies and products offered or any requirements that are preempted under section 2802; or

"(II) the State requires the issuer, as a condition of approval of the policy or product, to offer any policy or product other than such policy or product.

"(C) ENFORCEMENT.—In the case of a waiver granted under subparagraph (A) to an issuer with respect to a State, the Secretary may enter into an agreement with the State

under which the State agrees to provide for monitoring and enforcement activities with respect to compliance of such an issuer and its health insurance coverage with the applicable State standards described in subparagraph (A)(ii). Such monitoring and enforcement shall be conducted by the State in the same manner as the State enforces such standards with respect to other health insurance issuers and plans, without discrimination based on the type of issuer to which the standards apply. Such an agreement shall specify or establish mechanisms by which compliance activities are undertaken, while not lengthening the time required to review and process applications for waivers under subparagraph (A).

''(3) EXAMPLES OF TYPES OF COVERAGE.—The health benefits coverage made available through a HealthMart may include, but is not limited to, any of the following if it meets the other applicable requirements of this title:

''(A) Coverage through a health maintenance organization.

''(B) Coverage in connection with a preferred provider organization.

"(C) Coverage in connection with a licensed provider-sponsored organization.

"(D) Indemnity coverage through an insurance company.

"(E) Coverage offered in connection with a contribution into a medical savings account or flexible spending account.

"(F) Coverage that includes a point-of-service option.

"(G) Coverage offered by a community health organization (as defined in section 330B(e)).

"(H) Any combination of such types of coverage.

"(4) WELLNESS BONUSES FOR HEALTH PROMOTION.—Nothing in this title shall be construed as precluding a health insurance issuer offering health benefits coverage through a HealthMart from establishing premium discounts or rebates for members or from modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention so long as such programs are agreed to in advance by the HealthMart and comply with all other provisions of

this title and do not discriminate among similarly situated members.

''(c) PURCHASERS; MEMBERS; HEALTH INSURANCE ISSUERS.—

''(1) PURCHASERS.—

''(A) IN GENERAL.—Subject to the provisions of this title, a HealthMart shall permit any small employer to contract with the HealthMart for the purchase of health benefits coverage for its employees and dependents of those employees and may not vary conditions of eligibility (including premium rates and membership fees) of a small employer to be a purchaser.

''(B) ROLE OF ASSOCIATIONS, BROKERS, AND LICENSED HEALTH INSURANCE AGENTS.—Nothing in this section shall be construed as preventing an association, broker, licensed health insurance agent, or other entity from assisting or representing a HealthMart or small employers from entering into appropriate arrangements to carry out this title.

''(C) PERIOD OF CONTRACT.—The HealthMart may not require a contract under subparagraph (A) between a HealthMart and a

purchaser to be effective for a period of longer than 12 months. The previous sentence shall not be construed as preventing such a contract from being extended for additional 12-month periods or preventing the purchaser from voluntarily electing a contract period of longer than 12 months.

''(D) EXCLUSIVE NATURE OF CONTRACT.—Such a contract shall provide that the purchaser agrees not to obtain or sponsor health benefits coverage, on behalf of any eligible employees (and their dependents), other than through the HealthMart. The previous sentence shall not apply to an eligible individual who resides in an area for which no coverage is offered by any health insurance issuer through the HealthMart.

''(2) MEMBERS.—

''(A) IN GENERAL.—Under rules established to carry out this title, with respect to a small employer that has a purchaser contract with a HealthMart, individuals who are employees of the employer may enroll for health benefits coverage (including coverage for dependents

of such enrolling employees) offered by a health insurance issuer through the HealthMart.

"(B) NONDISCRIMINATION IN ENROLLMENT.—A HealthMart may not deny enrollment as a member to an individual who is an employee (or dependent of such an employee) eligible to be so enrolled based on health status-related factors, except as may be permitted consistent with section 2742(b).

"(C) ANNUAL OPEN ENROLLMENT PERIOD.—In the case of members enrolled in health benefits coverage offered by a health insurance issuer through a HealthMart, subject to subparagraph (D), the HealthMart shall provide for an annual open enrollment period of 30 days during which such members may change the coverage option in which the members are enrolled.

"(D) RULES OF ELIGIBILITY.—Nothing in this paragraph shall preclude a HealthMart from establishing rules of employee eligibility for enrollment and reenrollment of members during the annual open enrollment period under subparagraph (C). Such rules shall be applied consistently to all purchasers and members

within the HealthMart and shall not be based in any manner on health status-related factors and may not conflict with sections 2701 and 2702 of this Act.

''(3) HEALTH INSURANCE ISSUERS.—

''(A) PREMIUM COLLECTION.—The contract between a HealthMart and a health insurance issuer shall provide, with respect to a member enrolled with health benefits coverage offered by the issuer through the HealthMart, for the payment of the premiums collected by the HealthMart (or the issuer) for such coverage (less a pre-determined administrative charge negotiated by the HealthMart and the issuer) to the issuer.

''(B) SCOPE OF SERVICE AREA.—Nothing in this title shall be construed as requiring the service area of a health insurance issuer with respect to health insurance coverage to cover the entire geographic area served by a HealthMart.

''(C) AVAILABILITY OF COVERAGE OPTIONS.—A HealthMart shall enter into contracts with one or more health insurance issuers in a manner that assures that at least 2 health

insurance coverage options are made available in the geographic area specified under subsection (a)(3)(A).

''(d) PREVENTION OF CONFLICTS OF INTEREST.—

''(1) FOR BOARDS OF DIRECTORS.—A member of a board of directors of a HealthMart may not serve as an employee or paid consultant to the HealthMart, but may receive reasonable reimbursement for travel expenses for purposes of attending meetings of the board or committees thereof.

''(2) FOR BOARDS OF DIRECTORS OR EMPLOYEES.—An individual is not eligible to serve in a paid or unpaid capacity on the board of directors of a HealthMart or as an employee of the HealthMart, if the individual is employed by, represents in any capacity, owns, or controls any ownership interest in a organization from whom the HealthMart receives contributions, grants, or other funds not connected with a contract for coverage through the HealthMart.

''(3) EMPLOYMENT AND EMPLOYEE REPRESENTATIVES.—

''(A) IN GENERAL.—An individual who is serving on a board of directors of a HealthMart as a representative described in subparagraph

(A) or (B) of section 2801(a)(1) shall not be employed by or affiliated with a health insurance issuer or be licensed as or employed by or affiliated with a health care provider.

''(B) CONSTRUCTION.—For purposes of subparagraph (A), the term ''affiliated'' does not include membership in a health benefits plan or the obtaining of health benefits coverage offered by a health insurance issuer.

''(e) CONSTRUCTION.—

''(1) NETWORK OF AFFILIATED HEALTHMARTS.—Nothing in this section shall be construed as preventing one or more HealthMarts serving different areas (whether or not contiguous) from providing for some or all of the following (through a single administrative organization or otherwise):

''(A) Coordinating the offering of the same or similar health benefits coverage in different areas served by the different HealthMarts.

''(B) Providing for crediting of deductibles and other cost-sharing for individuals who are provided health benefits coverage through the HealthMarts (or affiliated HealthMarts) after—

"(i) a change of employers through which the coverage is provided, or

"(ii) a change in place of employment to an area not served by the previous HealthMart.

"(2) PERMITTING HEALTHMARTS TO ADJUST DISTRIBUTIONS AMONG ISSUERS TO REFLECT RELATIVE RISK OF ENROLLEES.—Nothing in this section shall be construed as precluding a HealthMart from providing for adjustments in amounts distributed among the health insurance issuers offering health benefits coverage through the HealthMart based on factors such as the relative health care risk of members enrolled under the coverage offered by the different issuers.

"(3) APPLICATION OF UNIFORM MINIMUM PARTICIPATION AND CONTRIBUTION RULES.—Nothing in this section shall be construed as precluding a HealthMart from establishing minimum participation and contribution rules (described in section 2711(e)(1)) for small employers that apply to become purchasers in the HealthMart, so long as such rules are applied uniformly for all health insurance issuers.

"SEC. 2802. APPLICATION OF CERTAIN LAWS AND REQUIREMENTS.

''(a) AUTHORITY OF STATES.—Nothing in this section shall be construed as preempting State laws relating to the following:

''(1) The regulation of underwriters of health coverage, including licensure and solvency requirements.

''(2) The application of premium taxes and required payments for guaranty funds or for contributions to high-risk pools.

''(3) The application of fair marketing requirements and other consumer protections (other than those specifically relating to an item described in subsection (b)).

''(4) The application of requirements relating to the adjustment of rates for health insurance coverage.

''(b) TREATMENT OF BENEFIT AND GROUPING REQUIREMENTS.—State laws insofar as they relate to any of the following are superseded and shall not apply to health benefits coverage made available through a HealthMart:

''(1) Benefit requirements for health benefits coverage offered through a HealthMart, including (but not limited to) requirements relating to cov-

erage of specific providers, specific services or conditions, or the amount, duration, or scope of benefits, but not including requirements to the extent required to implement title XXVII or other Federal law and to the extent the requirement prohibits an exclusion of a specific disease from such coverage.

''(2) Requirements (commonly referred to as fictitious group laws) relating to grouping and similar requirements for such coverage to the extent such requirements impede the establishment and operation of HealthMarts pursuant to this title.

''(3) Any other requirements (including limitations on compensation arrangements) that, directly or indirectly, preclude (or have the effect of precluding) the offering of such coverage through a HealthMart, if the HealthMart meets the requirements of this title.

Any State law or regulation relating to the composition or organization of a HealthMart is preempted to the extent the law or regulation is inconsistent with the provisions of this title.

''(c) APPLICATION OF ERISA FIDUCIARY AND DISCLOSURE REQUIREMENTS.—The board of directors of a HealthMart is deemed to be a plan administrator of an employee welfare benefit plan which is a group health plan

for purposes of applying parts 1 and 4 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 and those provisions of part 5 of such subtitle which are applicable to enforcement of such parts 1 and 4, and the HealthMart shall be treated as such a plan and the enrollees shall be treated as participants and beneficiaries for purposes of applying such provisions pursuant to this subsection.

''(d) APPLICATION OF ERISA RENEWABILITY PROTECTION.—A HealthMart is deemed to be group health plan that is a multiple employer welfare arrangement for purposes of applying section 703 of the Employee Retirement Income Security Act of 1974.

''(e) APPLICATION OF RULES FOR NETWORK PLANS AND FINANCIAL CAPACITY.—The provisions of subsections (c) and (d) of section 2711 apply to health benefits coverage offered by a health insurance issuer through a HealthMart.

''(f) CONSTRUCTION RELATING TO OFFERING REQUIREMENT.—Nothing in section 2711(a) of this Act or 703 of the Employee Retirement Income Security Act of 1974 shall be construed as permitting the offering outside the HealthMart of health benefits coverage that is only made available through a HealthMart under this section because of the application of subsection (b).

''(g) APPLICATION TO GUARANTEED RENEWABILITY REQUIREMENTS IN CASE OF DISCONTINUATION OF AN ISSUER.—For purposes of applying section 2712 in the case of health insurance coverage offered by a health insurance issuer through a HealthMart, if the contract between the HealthMart and the issuer is terminated and the HealthMart continues to make available any health insurance coverage after the date of such termination, the following rules apply:

''(1) RENEWABILITY.—The HealthMart shall fulfill the obligation under such section of the issuer renewing and continuing in force coverage by offering purchasers (and members and their dependents) all available health benefits coverage that would otherwise be available to similarly-situated purchasers and members from the remaining participating health insurance issuers in the same manner as would be required of issuers under section 2712(c).

''(2) APPLICATION OF ASSOCIATION RULES.—The HealthMart shall be considered an association for purposes of applying section 2712(e).

''(h) CONSTRUCTION IN RELATION TO CERTAIN OTHER LAWS.—Nothing in this title shall be construed as modifying or affecting the applicability to HealthMarts or health benefits coverage offered by a health insurance

issuer through a HealthMart of parts 6 and 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 or titles XXII and XXVII of this Act.

"SEC. 2803. ADMINISTRATION.

"(a) IN GENERAL.—The applicable Federal authority shall administer this title through the division established under subsection (b) and is authorized to issue such regulations as may be required to carry out this title. Such regulations shall be subject to Congressional review under the provisions of chapter 8 of title 5, United States Code. The applicable Federal authority shall incorporate the process of 'deemed file and use' with respect to the information filed under section 2801(a)(6)(A) and shall determine whether information filed by a HealthMart demonstrates compliance with the applicable requirements of this title. Such authority shall exercise its authority under this title in a manner that fosters and promotes the development of HealthMarts in order to improve access to health care coverage and services.

"(b) ADMINISTRATION THROUGH HEALTH CARE MARKETPLACE DIVISION.—

"(1) IN GENERAL.—The applicable Federal authority shall carry out its duties under this title through a separate Health Care Marketplace Divi-

sion, the sole duty of which (including the staff of which) shall be to administer this title.

''(2) ADDITIONAL DUTIES.—In addition to other responsibilities provided under this title, such Division is responsible for—

''(A) oversight of the operations of HealthMarts under this title; and

''(B) the periodic submittal to Congress of reports on the performance of HealthMarts under this title under subsection (c).

''(c) PERIODIC REPORTS.—The applicable Federal authority shall submit to Congress a report every 30 months, during the 10-year period beginning on the effective date of the rules promulgated by the applicable Federal authority to carry out this title, on the effectiveness of this title in promoting coverage of uninsured individuals. Such authority may provide for the production of such reports through one or more contracts with appropriate private entities.

''SEC. 2804. DEFINITIONS.

''For purposes of this title:

''(1) APPLICABLE FEDERAL AUTHORITY.—The term 'applicable Federal authority' means the Secretary of Health and Human Services .

"(2) ELIGIBLE EMPLOYEE OR INDIVIDUAL.—The term 'eligible' means, with respect to an employee or other individual and a HealthMart, an employee or individual who is eligible under section 2801(c)(2) to enroll or be enrolled in health benefits coverage offered through the HealthMart.

"(3) EMPLOYER; EMPLOYEE; DEPENDENT.—Except as the applicable Federal authority may otherwise provide, the terms 'employer', 'employee', and 'dependent', as applied to health insurance coverage offered by a health insurance issuer licensed (or otherwise regulated) in a State, shall have the meanings applied to such terms with respect to such coverage under the laws of the State relating to such coverage and such an issuer.

"(4) HEALTH BENEFITS COVERAGE.—The term 'health benefits coverage' has the meaning given the term group health insurance coverage in section 2791(b)(4).

"(5) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning given such term in section 2791(b)(2) and includes a community health organization that is offering coverage pursuant to section 330B(a).

''(6) HEALTH STATUS-RELATED FACTOR.—The term 'health status-related factor' has the meaning given such term in section 2791(d)(9).

''(7) HEALTHMART.—The term 'HealthMart' is defined in section 2801(a).

''(8) MEMBER.—The term 'member'' means, with respect to a HealthMart, an individual enrolled for health benefits coverage through the HealthMart under section 2801(c)(2).

''(9) PURCHASER.—The term 'purchaser' means, with respect to a HealthMart, a small employer that has contracted under section 2801(c)(1)(A) with the HealthMart for the purchase of health benefits coverage.

''(10) SMALL EMPLOYER.—The term 'small employer' has the meaning given such term for purposes of title XXVII.''.

Subtitle D—Community Health Organizations

SEC. 2301. PROMOTION OF PROVISION OF INSURANCE BY COMMUNITY HEALTH ORGANIZATIONS.

(a) WAIVER OF STATE LICENSURE REQUIREMENT FOR COMMUNITY HEALTH ORGANIZATIONS IN CERTAIN CASES.—Subpart I of part D of title III of the Public

Health Service Act is amended by adding at the end the following new section:

''WAIVER OF STATE LICENSURE REQUIREMENT FOR COMMUNITY HEALTH ORGANIZATIONS IN CERTAIN CASES

''SEC. 330B. (a) WAIVER AUTHORIZED.—

''(1) IN GENERAL.—A community health organization may offer health insurance coverage in a State notwithstanding that it is not licensed in such a State to offer such coverage if—

''(A) the organization files an application for waiver of the licensure requirement with the Secretary of Health and Human Services (in this section referred to as the 'Secretary') by not later than November 1, 2003, and

''(B) the Secretary determines, based on the application and other evidence presented to the Secretary, that any of the grounds for approval of the application described in subparagraph (A), (B), or (C) of paragraph (2) has been met.

''(2) GROUNDS FOR APPROVAL OF WAIVER.—

''(A) FAILURE TO ACT ON LICENSURE APPLICATION ON A TIMELY BASIS.—The ground for approval of such a waiver application described in this subparagraph is that the State has failed to complete action on a licensing ap-

plication of the organization within 90 days of the date of the State's receipt of a substantially complete application. No period before the date of the enactment of this section shall be included in determining such 90-day period.

"(B) DENIAL OF APPLICATION BASED ON DISCRIMINATORY TREATMENT.—The ground for approval of such a waiver application described in this subparagraph is that the State has denied such a licensing application and the standards or review process imposed by the State as a condition of approval of the license or as the basis for such denial by the State imposes any material requirements, procedures, or standards (other than solvency requirements) to such organizations that are not generally applicable to other entities engaged in a substantially similar business.

"(C) DENIAL OF APPLICATION BASED ON APPLICATION OF SOLVENCY REQUIREMENTS.—With respect to waiver applications filed on or after the date of publication of solvency standards established by the Secretary under subsection (d), the ground for approval of such a waiver application described in this subpara-

graph is that the State has denied such a licensing application based (in whole or in part) on the organization's failure to meet applicable State solvency requirements and such requirements are not the same as the solvency standards established by the Secretary. For purposes of this subparagraph, the term solvency requirements means requirements relating to solvency and other matters covered under the standards established by the Secretary under subsection (d).

''(3) TREATMENT OF WAIVER.—In the case of a waiver granted under this subsection for a community health organization with respect to a State—

''(A) LIMITATION TO STATE.—The waiver shall be effective only with respect to that State and does not apply to any other State.

''(B) LIMITATION TO 36-MONTH PERIOD.—The waiver shall be effective only for a 36-month period but may be renewed for up to 36 additional months if the Secretary determines that such an extension is appropriate.

''(C) CONDITIONED ON COMPLIANCE WITH CONSUMER PROTECTION AND QUALITY STANDARDS.—The continuation of the waiver is condi-

tioned upon the organization's compliance with the requirements described in paragraph (5).

"(D) PREEMPTION OF STATE LAW.—Any provisions of law of that State which relate to the licensing of the organization and which prohibit the organization from providing health insurance coverage shall be superseded.

"(4) PROMPT ACTION ON APPLICATION.—The Secretary shall grant or deny such a waiver application within 60 days after the date the Secretary determines that a substantially complete waiver application has been filed. Nothing in this section shall be construed as preventing an organization which has had such a waiver application denied from submitting a subsequent waiver application.

"(5) APPLICATION AND ENFORCEMENT OF STATE CONSUMER PROTECTION AND QUALITY STANDARDS.—A waiver granted under this subsection to an organization with respect to licensing under State law is conditioned upon the organization's compliance with all consumer protection and quality standards insofar as such standards—

"(A) would apply in the State to the community health organization if it were licensed as

an entity offering health insurance coverage under State law; and

"(B) are generally applicable to other risk-bearing managed care organizations and plans in the State.

"(6) REPORT.—By not later than December 31, 2002, the Secretary shall submit to the Committee on Commerce of the House of Representatives and the Committee on Labor and Human Resources of the Senate a report regarding whether the waiver process under this subsection should be continued after December 31, 2003.

"(b) ASSUMPTION OF FULL FINANCIAL RISK.—To qualify for a waiver under subsection (a), the community health organization shall assume full financial risk on a prospective basis for the provision of covered health care services, except that the organization—

"(1) may obtain insurance or make other arrangements for the cost of providing to any enrolled member such services the aggregate value of which exceeds such aggregate level as the Secretary specifies from time to time;

"(2) may obtain insurance or make other arrangements for the cost of such services provided to its enrolled members other than through the organi-

zation because medical necessity required their provision before they could be secured through the organization;

''(3) may obtain insurance or make other arrangements for not more than 90 percent of the amount by which its costs for any of its fiscal years exceed 105 percent of its income for such fiscal year; and

''(4) may make arrangements with physicians or other health care professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of health services by the physicians or other health professionals or through the institutions.

''(c) CERTIFICATION OF PROVISION AGAINST RISK OF INSOLVENCY FOR UNLICENSED CHOS.—

''(1) IN GENERAL.—Each community health organization that is not licensed by a State and for which a waiver application has been approved under subsection (a)(1), shall meet standards established by the Secretary under subsection (d) relating to the financial solvency and capital adequacy of the organization.

''(2) CERTIFICATION PROCESS FOR SOLVENCY STANDARDS FOR CHOS.—The Secretary shall establish a process for the receipt and approval of applications of a community health organization described in paragraph (1) for certification (and periodic recertification) of the organization as meeting such solvency standards. Under such process, the Secretary shall act upon such a certification application not later than 60 days after the date the application has been received.

''(d) ESTABLISHMENT OF SOLVENCY STANDARDS FOR COMMUNITY HEALTH ORGANIZATIONS.—

''(1) IN GENERAL.—The Secretary shall establish, on an expedited basis and by rule pursuant to section 553 of title 5, United States Code and through the Health Resources and Services Administration, standards described in subsection (c)(1) (relating to financial solvency and capital adequacy) that entities must meet to obtain a waiver under subsection (a)(2)(C). In establishing such standards, the Secretary shall consult with interested organizations, including the National Association of Insurance Commissioners, the Academy of Actuaries, and organizations representing Federally qualified health centers.

''(2) FACTORS TO CONSIDER FOR SOLVENCY STANDARDS.—In establishing solvency standards for community health organizations under paragraph (1), the Secretary shall take into account—

''(A) the delivery system assets of such an organization and ability of such an organization to provide services to enrollees;

''(B) alternative means of protecting against insolvency, including reinsurance, unrestricted surplus, letters of credit, guarantees, organizational insurance coverage, partnerships with other licensed entities, and valuation attributable to the ability of such an organization to meet its service obligations through direct delivery of care; and

''(C) any standards developed by the National Association of Insurance Commissioners specifically for risk-based health care delivery organizations.

''(3) ENROLLEE PROTECTION AGAINST INSOLVENCY.—Such standards shall include provisions to prevent enrollees from being held liable to any person or entity for the organization's debts in the event of the organization's insolvency.

''(4) DEADLINE.—Such standards shall be promulgated in a manner so they are first effective by not later than April 1, 1999.

''(e) DEFINITIONS.—In this section:

''(1) COMMUNITY HEALTH ORGANIZATION.—The term 'community health organization ' means an organization that is a Federally-qualified health center or is controlled by one or more Federally-qualified health centers.

''(2) FEDERALLY-QUALIFIED HEALTH CENTER.—The term 'Federally-qualified health center' has the meaning given such term in section 1905(l)(2)(B) of the Social Security Act.

''(3) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning given such term in section 2791(b)(1).

''(4) CONTROL.—The term 'control' means the possession, whether direct or indirect, of the power to direct or cause the direction of the management and policies of the organization through membership, board representation, or an ownership interest equal to or greater than 50.1 percent.''.

TITLE III—AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986

Subtitle A—Patient Protections

SEC. 3001. PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE, EMERGENCY MEDICAL CARE, OBSTETRIC AND GYNECOLOGICAL CARE, PEDIATRIC CARE.

(a) IN GENERAL.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 (relating to other requirements) is amended by adding at the end the following new section:

"SEC. 9813. PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE, EMERGENCY MEDICAL CARE, OBSTETRIC AND GYNECOLOGICAL CARE, PEDIATRIC CARE.

''(a) PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE.—

''(1) IN GENERAL.—In the case of any health care professional acting within the lawful scope of practice in the course of carrying out a contractual employment arrangement or other direct contractual arrangement between such professional and a group health plan, the plan with which such contractual employment arrangement or other direct contractual

arrangement is maintained by the professional may not impose on such professional under such arrangement any prohibition with respect to advice, provided to a participant or beneficiary under the plan who is a patient, about the health status of the participant or beneficiary or the medical care or treatment for the condition or disease of the participant or beneficiary, regardless of whether benefits for such care or treatment are provided under the plan.

''(2) HEALTH CARE PROFESSIONAL DEFINED.—For purposes of this subsection, the term 'health care professional' means a physician (as defined in section 1861(r) of the Social Security Act) or other health care professional if coverage for the professional's services is provided under the group health plan for the services of the professional. Such term includes a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist and therapy assistant, speech–language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse–midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

"(b) PATIENT ACCESS TO EMERGENCY MEDICAL CARE.—

"(1) IN GENERAL.—To the extent that the group health plan provides for any benefits consisting of emergency medical care (as defined in section 503(b)(9)(I) of the Employee Retirement Income Security Act of 1974), except for items or services specifically excluded—

"(A) the plan shall provide benefits, without requiring preauthorization, for appropriate emergency medical screening examinations (within the capability of the emergency facility, including ancillary services routinely available to the emergency facility) to the extent that a prudent layperson, who possesses an average knowledge of health and medicine, would determine such examinations to be necessary in order to determine whether emergency medical care (as so defined) is required, and

"(B) the plan shall provide benefits for additional emergency medical services following an emergency medical screening examination (if determined necessary under subparagraph (A)) to the extent that a prudent emergency medical professional would determine such additional

emergency services to be necessary to avoid the consequences described in clause (i) of section 503(b)(9)(I) of such Act.

''(2) UNIFORM COST-SHARING REQUIRED.—Nothing in this subsection shall be construed as preventing a group health plan from imposing any form of cost-sharing applicable to any participant or beneficiary (including coinsurance, copayments, deductibles, and any other charges) in relation to benefits described in paragraph (1), if such form of cost-sharing is uniformly applied under such plan, with respect to similarly situated participants and beneficiaries, to all benefits consisting of emergency medical care (as defined in section 503(b)(9)(I) of the Employee Retirement Income Security Act of 1974) provided to such similarly situated participants and beneficiaries under the plan.

''(c) PATIENT ACCESS TO OBSTETRIC AND GYNECOLOGICAL CARE.

''(1) IN GENERAL.—In any case in which a group health plan—

''(A) provides benefits under the terms of the plan consisting of—

"(i) routine gynecological care (such as preventive women's health examinations), or

"(ii) routine obstetric care (such as routine pregnancy-related services),

provided by a participating physician who specializes in such care (or provides benefits consisting of payment for such care), and

"(B) the plan requires or provides for designation by a participant or beneficiary of a participating primary care provider,

if the primary care provider designated by such a participant or beneficiary is not such a physician, then the plan shall meet the requirements of paragraph (2).

"(2) REQUIREMENTS.—A group health plan meets the requirements of this paragraph, in connection with benefits described in paragraph (1) consisting of care described in clause (i) or (ii) of paragraph (1)(A) (or consisting of payment therefor), if the plan—

"(A) does not require authorization or a referral by the primary care provider in order to obtain such benefits, and

"(B) treats the ordering of other routine care of the same type, by the participating physician providing the care described in clause (i) or (ii) of paragraph (1)(A), as the authorization of the primary care provider with respect to such care.

"(3) CONSTRUCTION.—Nothing in paragraph (2)(B) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of gynecological or obstetric care so ordered.

"(d) PATIENT ACCESS TO PEDIATRIC CARE.—

"(1) IN GENERAL.—In any case in which a group health plan (or a health insurance issuer offering health insurance coverage in connection with the plan) provides benefits consisting of routine pediatric care provided by a participating physician who specializes in pediatrics (or consisting of payment for such care) and the plan requires or provides for designation by a participant or beneficiary of a participating primary care provider, the plan (or issuer) shall provide that such a participating physician may be designated, if available, by a parent or guardian of any beneficiary under the plan is who

under 18 years of age, as the primary care provider with respect to any such benefits.

''(2) CONSTRUCTION.—Nothing in paragraph (1) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of pediatric care.

''(e) TREATMENT OF MULTIPLE COVERAGE OPTIONS.—In the case of a plan providing benefits under two or more coverage options, the requirements of subsections (c) and (d) shall apply separately with respect to each coverage option.''.

(b) CLERICAL AMENDMENT.—The table of sections of such subchapter of such chapter is amended by adding at the end the following new item:

''Sec. 9813. Patient access to unrestricted medical advice, emergency medical care, obstetric and gynecological care, pediatric care.''

SEC. 3002. EFFECTIVE DATE AND RELATED RULES.

(a) IN GENERAL.—The amendments made by this subtitle shall apply with respect to plan years beginning on or after January 1 of the second calendar year following the date of the enactment of this Act, except that the Secretary of the Treasury may issue regulations before such date under such amendments. The Secretary shall first issue regulations necessary to carry out the amendments made by this section before the effective date thereof.

(b) LIMITATION ON PENALTY FOR CERTAIN FAILURES.—No penalty shall be imposed on any failure to comply with any requirement imposed by the amendments made by section 3101 to the extent such failure occurs before the date of issuance of regulations issued in connection with such requirement if the plan has sought to comply in good faith with such requirement.

(c) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the provisions of subsections (b), (c), and (d) of section 9813 of the Internal Revenue Code of 1986 (as added by this subtitle) shall not apply with respect to plan years beginning before the later of—

(1) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

(2) January 1, 2001.

For purposes of this subsection, any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the

plan solely to conform to any requirement added by this subtitle shall not be treated as a termination of such collective bargaining agreement.

Subtitle B—Patient Access to Information

SEC. 3101. PATIENT ACCESS TO INFORMATION REGARDING PLAN COVERAGE, MANAGED CARE PROCEDURES, HEALTH CARE PROVIDERS, AND QUALITY OF MEDICAL CARE.

(a) IN GENERAL.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 (relating to other requirements) is amended by adding at the end the following new section:

"SEC. 9814. DISCLOSURE BY GROUP HEALTH PLANS.

''(a) DISCLOSURE REQUIREMENT.—The administrator of each group health plan shall take such actions as are necessary to ensure that the summary plan description of the plan required under section 102 of Employee Retirement Income Security Act of 1974 (or each summary plan description in any case in which different summary plan descriptions are appropriate under part 1 of subtitle B of title I of such Act for different options of coverage) contains the information required under subsections (b), (c), (d), and (e)(2)(A). To the extent that any health insurance issuer offering health insurance cov-

erage in connection with such plan provides such information on a timely basis to plan participants and beneficiaries, the requirements of this subsection shall be deemed satisfied in the case of such plan with respect to such information.

''(b) PLAN BENEFITS.—The information required under subsection (a) includes the following:

''(1) COVERED ITEMS AND SERVICES.—

''(A) CATEGORIZATION OF INCLUDED BENEFITS.—A description of covered benefits, categorized by—

''(i) types of items and services (including any special disease management program), and

''(ii) types of health care professionals providing such items and services.

''(B) EMERGENCY MEDICAL CARE.—A description of the extent to which the plan covers emergency medical care (including the extent to which the plan provides for access to urgent care centers), and any definitions provided under the plan for the relevant plan terminology referring to such care.

"(C) PREVENTATIVE SERVICES.—A description of the extent to which the plan provides benefits for preventative services.

"(D) DRUG FORMULARIES.—A description of the extent to which covered benefits are determined by the use or application of a drug formulary and a summary of the process for determining what is included in such formulary.

"(E) COBRA CONTINUATION COVERAGE.—A description of the requirements under section 4980B.

"(2) LIMITATIONS, EXCLUSIONS, AND RESTRICTIONS ON COVERED BENEFITS.—

"(A) CATEGORIZATION OF EXCLUDED BENEFITS.—A description of benefits specifically excluded from coverage, categorized by types of items and services.

"(B) UTILIZATION REVIEW AND PREAUTHORIZATION REQUIREMENTS.—Whether coverage for medical care is limited or excluded on the basis of utilization review or preauthorization requirements.

"(C) LIFETIME, ANNUAL, OR OTHER PERIOD LIMITATIONS.—A description of the circumstances under which, and the extent to

which, coverage is subject to lifetime, annual, or other period limitations, categorized by types of benefits.

''(D) CUSTODIAL CARE.—A description of the circumstances under which, and the extent to which, the coverage of benefits for custodial care is limited or excluded, and a statement of the definition used by the plan for custodial care.

''(E) EXPERIMENTAL TREATMENTS.—Whether coverage for any medical care is limited or excluded because it constitutes experimental treatment or technology, and any definitions provided under the plan for the relevant plan terminology referring to such limited or excluded care.

''(F) MEDICAL APPROPRIATENESS OR NECESSITY.—Whether coverage for medical care may be limited or excluded by reason of a failure to meet the plan's requirements for medical appropriateness or necessity, and any definitions provided under the plan for the relevant plan terminology referring to such limited or excluded care.

"(G) SECOND OR SUBSEQUENT OPINIONS.—A description of the circumstances under which, and the extent to which, coverage for second or subsequent opinions is limited or excluded.

"(H) SPECIALTY CARE.—A description of the circumstances under which, and the extent to which, coverage of benefits for specialty care is conditioned on referral from a primary care provider.

"(I) CONTINUITY OF CARE.—A description of the circumstances under which, and the extent to which, coverage of items and services provided by any health care professional is limited or excluded by reason of the departure by the professional from any defined set of providers.

"(J) RESTRICTIONS ON COVERAGE OF EMERGENCY SERVICES.—A description of the circumstances under which, and the extent to which, the plan, in covering emergency medical care furnished to a participant or beneficiary of the plan imposes any financial responsibility described in subsection (c) on participants or beneficiaries or limits or conditions benefits for

such care subject to any other term or condition of such plan.

''(c) PARTICIPANT'S FINANCIAL RESPONSIBILITIES.—The information required under subsection (a) includes an explanation of—

''(1) a participant's financial responsibility for payment of premiums, coinsurance, copayments, deductibles, and any other charges, and

''(2) the circumstances under which, and the extent to which, the participant's financial responsibility described in paragraph (1) may vary, including any distinctions based on whether a health care provider from whom covered benefits are obtained is included in a defined set of providers.

''(d) DISPUTE RESOLUTION PROCEDURES.—The information required under subsection (a) includes a description of the processes adopted by the plan pursuant to section 503(b) of Employee Retirement Income Security Act of 1974, including—

''(1) descriptions thereof relating specifically to—

''(A) coverage decisions,

''(B) internal review of coverage decisions, and

''(C) any external review of coverage decisions, and

''(2) the procedures and time frames applicable to each step of the processes referred to in subparagraphs (A), (B), and (C) of paragraph (1).

''(e) INFORMATION AVAILABLE ON REQUEST.—

''(1) ACCESS TO PLAN BENEFIT INFORMATION IN ELECTRONIC FORM.—

''(A) IN GENERAL.—A group health plan shall, upon written request (made not more frequently than annually), make available to participants and beneficiaries, in a generally recognized electronic format, the following information:

''(i) the latest summary plan description, including the latest summary of material modifications; and

''(ii) the actual plan provisions setting forth the benefits available under the plan to the extent such information relates to the coverage options under the plan available to the participant or beneficiary. A reasonable charge may be made to cover the cost of providing such information in such generally recognized electronic format. The Secretary may by regula-

tion prescribe a maximum amount which will constitute a reasonable charge under the preceding sentence.

''(B) ALTERNATIVE ACCESS.—The requirements of this paragraph may be met by making such information generally available (rather than upon request) on the Internet or on a proprietary computer network in a format which is readily accessible to participants and beneficiaries.

''(2) ADDITIONAL INFORMATION TO BE PROVIDED ON REQUEST.—

''(A) INCLUSION IN SUMMARY PLAN DESCRIPTION OF SUMMARY OF ADDITIONAL INFORMATION.—The information required under subsection (a) includes a summary description of the types of information required by this subsection to be made available to participants and beneficiaries on request.

''(B) INFORMATION REQUIRED FROM PLANS ON REQUEST.—In addition to information required to be included in summary plan descriptions under this subsection, a group health plan shall provide the following information to a participant or beneficiary on request:

''(i) NETWORK CHARACTERISTICS.—If the plan (or a health insurance issuer offering health insurance coverage in connection with the plan) utilizes a defined set of providers under contract with the plan (or issuer), a detailed list of the names of such providers and their geographic location, set forth separately with respect to primary care providers and with respect to specialists.

''(ii) CARE MANAGEMENT INFORMATION.—A description of the circumstances under which, and the extent to which, the plan has special disease management programs or programs for persons with disabilities, indicating whether these programs are voluntary or mandatory and whether a significant benefit differential results from participation in such programs.

''(iii) INCLUSION OF DRUGS AND BIOLOGICALS IN FORMULARIES.—A statement of whether a specific drug or biological is included in a formulary used to determine benefits under the plan and a de-

scription of the procedures for considering requests for any patient-specific waivers.

''(iv) PROCEDURES FOR DETERMINING EXCLUSIONS BASED ON MEDICAL NECESSITY OR EXPERIMENTAL TREATMENTS.—Upon receipt by the participant or beneficiary of any notification of an adverse coverage decision based on a determination relating to medical necessity or an experimental treatment or technology, a description of the procedures and medically-based criteria used in such decision.

''(v) PREAUTHORIZATION AND UTILIZATION REVIEW PROCEDURES.—Upon receipt by the participant or beneficiary of any notification of an adverse coverage decision, a description of the basis on which any preauthorization requirement or any utilization review requirement has resulted in such decision.

''(vi) ACCREDITATION STATUS OF HEALTH INSURANCE ISSUERS AND SERVICE PROVIDERS.—A description of the accreditation and licencing status (if any) of each health insurance issuer offering

health insurance coverage in connection with the plan and of any utilization review organization utilized by the issuer or the plan, together with the name and address of the accrediting or licencing authority.

''(vii) MEASURES OF ENROLLEE SATISFACTION.—The latest information (if any) maintained by the plan, or by any health insurance issuer offering health insurance coverage in connection with the plan, relating to enrollee satisfaction.

''(viii) QUALITY PERFORMANCE MEASURES.—The latest information (if any) maintained by the plan, or by any health insurance issuer offering health insurance coverage in connection with the plan, relating to quality of performance of the delivery of medical care with respect to coverage options offered under the plan and of health care professionals and facilities providing medical care under the plan.

''(C) INFORMATION REQUIRED FROM HEALTH CARE PROFESSIONALS ON REQUEST.—Any health care professional treating a participant or beneficiary under a group health plan

shall provide to the participant or beneficiary, on request, a description of his or her professional qualifications (including board certification status, licensing status, and accreditation status, if any), privileges, and experience and a general description by category (including salary, fee-for-service, capitation, and such other categories as may be specified in regulations of the Secretary) of the applicable method by which such professional is compensated in connection with the provision of such medical care.

''(D) INFORMATION REQUIRED FROM HEALTH CARE FACILITIES ON REQUEST.—Any health care facility from which a participant or beneficiary has sought treatment under a group health plan shall provide to the participant or beneficiary, on request, a description of the facility's corporate form or other organizational form and all forms of licensing and accreditation status (if any) assigned to the facility by standard-setting organizations.

''(f) ACCESS TO INFORMATION RELEVANT TO THE COVERAGE OPTIONS UNDER WHICH THE PARTICIPANT OR BENEFICIARY IS ELIGIBLE TO ENROLL.—In addition to information otherwise required to be made available under

this section, a group health plan shall, upon written request (made not more frequently than annually), make available to a participant in connection with a period of enrollment the summary plan description for any coverage option under the plan under which the participant is eligible to enroll and any information described in clauses (i), (ii), (iii), (vi), (vii), and (viii) of subsection (e)(2)(B).

''(g) ADVANCE NOTICE OF CHANGES IN DRUG FORMULARIES.—Not later than 30 days before the effective of date of any exclusion of a specific drug or biological from any drug formulary under the plan that is used in the treatment of a chronic illness or disease, the plan shall take such actions as are necessary to reasonably ensure that plan participants are informed of such exclusion. The requirements of this subsection may be satisfied—

''(1) by inclusion of information in publications broadly distributed by plan sponsors, employers, or employee organizations,

''(2) by electronic means of communication (including the Internet or proprietary computer networks in a format which is readily accessible to participants),

''(3) by timely informing participants who, under an ongoing program maintained under the

plan, have submitted their names for such notification, or

''(4) by any other reasonable means of timely informing plan participants.''.

(b) CLERICAL AMENDMENT.—The table of sections of such subchapter of such chapter is amended by adding at the end the following new item:

''Sec. 9814. Disclosure by group health plans.''

SEC. 3102. REPORTING ON FRAUD AND ABUSE ENFORCEMENT ACTIVITIES.

The General Accounting Office shall—

(1) monitor—

(A) the compliance of the Department of Justice and all United States Attorneys–with the guideline entitled ''Guidance on the Use of the False Claims Act in Civil Health Care Matters'' issued by the Department on June 3, 1998, including any revisions to that guideline, and

(B) the compliance of the Office of the Inspector General of the Department of Health and Human Services with the protocols and guidelines entitled ''National Project Protocols—Best Practice Guidelines'' issued by the Inspector General on June 3, 1998, including

any revisions to such protocols and guidelines, and

(2) submit a report on such compliance to the Committee on the Judiciary and the Committee on Ways and Means of the House of Representatives and the Committee on the Judiciary and the Committee on Finance of the Senate not later than February 1, 1999, and every year thereafter for a period of four years ending February 1, 2002.

SEC. 3103. EFFECTIVE DATE.

(a) IN GENERAL.—The amendments made by this subtitle shall apply with respect to plan years beginning on or after January 1 of the second calendar year following the date of the enactment of this Act. The Secretary of the Treasury or the Secretary's delegate shall first issue all regulations necessary to carry out the amendments made by this subtitle before such date.

(b) LIMITATION ON ENFORCEMENT ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this subtitle, against a group health plan with respect to a violation of a requirement imposed by such amendments before the date of issuance of final regulations issued in connection with such requirement, if the plan has sought to comply in good faith with such requirement.

Subtitle C—Medical Savings Accounts

SEC. 3201. EXPANSION OF AVAILABILITY OF MEDICAL SAVINGS ACCOUNTS.

(a) REPEAL OF LIMITATIONS ON NUMBER OF MEDICAL SAVINGS ACCOUNTS.—

(1) IN GENERAL.—Subsections (i) and (j) of section 220 of the Internal Revenue Code of 1986 are hereby repealed.

(2) CONFORMING AMENDMENT.—Paragraph (1) of section 220(c) of such Code is amended by striking subparagraph (D).

(b) ALL EMPLOYERS MAY OFFER MEDICAL SAVINGS ACCOUNTS.—

(1) IN GENERAL.—Subclause (I) of section 220(c)(1)(A)(iii) of such Code (defining eligible individual) is amended by striking ''and such employer is a small employer''.

(2) CONFORMING AMENDMENTS.—

(A) Paragraph (1) of section 220(c) of such Code is amended by striking subparagraph (C).

(B) Subsection (c) of section 220 of such Code is amended by striking paragraph (4) and

by redesignating paragraph (5) as paragraph (4).

(c) INCREASE IN AMOUNT OF DEDUCTION ALLOWED FOR CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—

(1) IN GENERAL.—Paragraph (2) of section 220(b) of such Code is amended to read as follows:

''(2) MONTHLY LIMITATION.—The monthly limitation for any month is the amount equal to 1/12 of the annual deductible (as of the first day of such month) of the taxpayer's coverage under the high deductible health plan.''

(2) CONFORMING AMENDMENT.—Clause (ii) of section 220(d)(1)(A) of such Code is amended by striking ''75 percent of''.

(d) BOTH EMPLOYERS AND EMPLOYEES MAY CONTRIBUTE TO MEDICAL SAVINGS ACCOUNTS.—Paragraph (5) of section 220(b) of such Code is amended to read as follows:

''(5) COORDINATION WITH EXCLUSION FOR EMPLOYER CONTRIBUTIONS.—The limitation which would (but for this paragraph) apply under this subsection to the taxpayer for any taxable year shall be reduced (but not below zero) by the amount which would (but for section 106(b)) be includible in the taxpayer's gross income for such taxable year.''

(e) REDUCTION OF PERMITTED DEDUCTIBLES UNDER HIGH DEDUCTIBLE HEALTH PLANS.—

(1) IN GENERAL.—Subparagraph (A) of section 220(c)(2) of such Code (defining high deductible health plan) is amended—

(A) by striking ''$1,500'' and inserting ''$1,000'', and

(B) by striking ''$3,000'' and inserting ''$2,000''.

(2) CONFORMING AMENDMENT.—Subsection (g) of section 220 of such Code is amended—

(A) by striking ''1998'' and inserting ''1999'', and

(B) by striking ''1997'' and inserting ''1998''.

(f) MEDICAL SAVINGS ACCOUNTS MAY BE OFFERED UNDER CAFETERIA PLANS.—Subsection (f) of section 125 of such Code is amended by striking ''106(b),''.

(g) INDIVIDUALS RECEIVING IMMEDIATE FEDERAL ANNUITIES ELIGIBLE FOR MEDICAL SAVINGS ACCOUNTS.—Paragraph (1) of section 220(c) of such Code (defining eligible individual), as amended by subsections (a) and (b), is amended by adding at the end the following new subparagraph:

"(C) SPECIAL RULES FOR INDIVIDUALS RECEIVING IMMEDIATE FEDERAL ANNUITIES.—

"(i) IN GENERAL.—Subparagraph (A)(iii) and subsection (b)(4) shall not apply for any month to an individual—

"(I) who, as of the 1st day of such month, is enrolled in a high deductible health plan under chapter 89 of title 5, United States Code, and

"(II) who is entitled to receive for such month any amount by reason of being an annuitant (as defined in section 8901(3) of such title 5).

"(ii) SPECIAL RULE FOR SPOUSE OF ANNUITANT.—In the case of the spouse of an individual described in clause (i) who is not also described in clause (i), subsection (b)(4) shall not apply to such spouse if such individual and spouse have family coverage under the same plan described in clause (i)(I)."

(h) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years ending after the date of the enactment of this Act.

SEC. 3202. EXCEPTION FROM INSURANCE LIMITATION IN CASE OF MEDICAL SAVINGS ACCOUNTS.

(a) IN GENERAL.—Section 220(d)(2)(B) of the Internal Revenue Code of 1986 is amended by adding at the end the following new clause:

"(iii) INSURANCE OFFERED BY COMMUNITY HEALTH CENTERS.—

"(I) IN GENERAL.—Subject to clauses (II) and (III), clause (i) shall not apply to any expense for coverage under insurance offered by a health center (as defined in section 330(a)(1) of the Public Health Service Act) if the coverage consists solely of coverage for required primary health benefits (as defined in section 330(b)(1)(A) of such Act) provided on a capitated basis.

"(II) INCOME LIMITATION.—Subclause (I) shall only apply to expenses for coverage of an individual who, in the taxable year involved, has income that is less than 200 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in ac-

cordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

''(III) LIMITATION ON NUMBER OF CONTRACTS.—For a taxable year ending in a calendar year, subclause (I) shall apply only to expenses for coverage for the first 15,000 individuals enrolled in insurance described in such subclause in the year.''.

(b) REPORTS ON ENROLLMENT.—Section 330(j)(3) of the Public Health Service Act (42 U.S.C. 254c(j)(3)) is amended—

(1) by striking ''and'' at the end of subparagraph (K),

(2) by striking the period at the end of subparagraph (L) and inserting ''; and'', and

(3) by inserting after subparagraph (L) the following new subparagraph:

''(M) if the center offers insurance coverage to an individual with a medical savings account under subclause (I) of section 220(d)(2)(B)(iii), the center shall provide such reports in such time and manner as may be re-

quired by the Secretary and the Secretary of the Treasury in order to carry out subclause (III) of such section.''.

TITLE IV—HEALTH CARE LAWSUIT REFORM

Subtitle A—General Provisions

SEC. 4001. FEDERAL REFORM OF HEALTH CARE LIABILITY ACTIONS.

(a) APPLICABILITY.—This title shall apply with respect to any health care liability action brought in any State or Federal court, except that this title shall not apply to—

(1) an action for damages arising from a vaccine-related injury or death to the extent that title XXI of the Public Health Service Act applies to the action, or

(2) an action under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.).

(b) PREEMPTION.—This title shall preempt any State law to the extent such law is inconsistent with the limitations contained in this title. This title shall not preempt any State law that provides for defenses or places limitations on a person's liability in addition to those contained

in this title or otherwise imposes greater restrictions than those provided in this title.

(c) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE OF LAW OR VENUE.—Nothing in subsection (b) shall be construed to—

(1) waive or affect any defense of sovereign immunity asserted by any State under any provision of law;

(2) waive or affect any defense of sovereign immunity asserted by the United States;

(3) affect the applicability of any provision of the Foreign Sovereign Immunities Act of 1976;

(4) preempt State choice-of-law rules with respect to claims brought by a foreign nation or a citizen of a foreign nation; or

(5) affect the right of any court to transfer venue or to apply the law of a foreign nation or to dismiss a claim of a foreign nation or of a citizen of a foreign nation on the ground of inconvenient forum.

(d) AMOUNT IN CONTROVERSY.—In an action to which this title applies and which is brought under section 1332 of title 28, United States Code, the amount of noneconomic damages or punitive damages, and attorneys' fees or costs, shall not be included in determining whether

the matter in controversy exceeds the sum or value of $50,000.

(e) FEDERAL COURT JURISDICTION NOT ESTABLISHED ON FEDERAL QUESTION GROUNDS.—Nothing in this title shall be construed to establish any jurisdiction in the district courts of the United States over health care liability actions on the basis of section 1331 or 1337 of title 28, United States Code.

SEC. 4002. DEFINITIONS.

As used in this title:

(1) ACTUAL DAMAGES.—The term ''actual damages'' means damages awarded to pay for economic loss.

(2) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term ''alternative dispute resolution system'' or ''ADR'' means a system established under Federal or State law that provides for the resolution of health care liability claims in a manner other than through health care liability actions.

(3) CLAIMANT.—The term ''claimant'' means any person who brings a health care liability action and any person on whose behalf such an action is brought. If such action is brought through or on behalf of an estate, the term includes the claimant's decedent. If such action is brought through or on be-

half of a minor or incompetent, the term includes the claimant's legal guardian.

(4) CLEAR AND CONVINCING EVIDENCE.—The term ''clear and convincing evidence'' is that measure or degree of proof that will produce in the mind of the trier of fact a firm belief or conviction as to the truth of the allegations sought to be established. Such measure or degree of proof is more than that required under preponderance of the evidence but less than that required for proof beyond a reasonable doubt.

(5) COLLATERAL SOURCE PAYMENTS.—The term ''collateral source payments'' means any amount paid or reasonably likely to be paid in the future to or on behalf of a claimant, or any service, product, or other benefit provided or reasonably likely to be provided in the future to or on behalf of a claimant, as a result of an injury or wrongful death, pursuant to—

(A) any State or Federal health, sickness, income-disability, accident or workers' compensation Act;

(B) any health, sickness, income-disability, or accident insurance that provides health benefits or income-disability coverage;

(C) any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or income disability benefits; and

(D) any other publicly or privately funded program.

(6) DRUG.—The term ''drug'' has the meaning given such term in section 201(g)(1) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(g)(1)).

(7) ECONOMIC LOSS.—The term ''economic loss'' means any pecuniary loss resulting from injury (including the loss of earnings or other benefits related to employment, medical expense loss, replacement services loss, loss due to death, burial costs, and loss of business or employment opportunities), to the extent recovery for such loss is allowed under applicable State law.

(8) HARM.—The term ''harm'' means any legally cognizable wrong or injury for which punitive damages may be imposed.

(9) HEALTH BENEFIT PLAN.—The term ''health benefit plan'' means—

(A) a hospital or medical expense incurred policy or certificate,

(B) a hospital or medical service plan contract,

(C) a health maintenance subscriber contract, or

(D) a Medicare+Choice plan (offered under part C of title XVIII of the Social Security Act),

that provides benefits with respect to health care services.

(10) HEALTH CARE LIABILITY ACTION.—The term ''health care liability action'' means a civil action brought in a State or Federal court against—

(A) a health care provider,

(B) an entity which is obligated to provide or pay for health benefits under any health benefit plan (including any person or entity acting under a contract or arrangement to provide or administer any health benefit), or

(C) the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product,

in which the claimant alleges a claim (including third party claims, cross claims, counter claims, or contribution

claims) based upon the provision of (or the failure to provide or pay for) health care services or the use of a medical product, regardless of the theory of liability on which the claim is based or the number of plaintiffs, defendants, or causes of action.

(11) HEALTH CARE LIABILITY CLAIM.—The term ''health care liability claim'' means a claim in which the claimant alleges that injury was caused by the provision of (or the failure to provide) health care services.

(12) HEALTH CARE PROVIDER.—The term ''health care provider'' means any person that is engaged in the delivery of health care services in a State and that is required by the laws or regulations of the State to be licensed or certified by the State to engage in the delivery of such services in the State.

(13) HEALTH CARE SERVICE.—The term ''health care service'' means any service eligible for payment under a health benefit plan, including services related to the delivery or administration of such service.

(14) MEDICAL DEVICE.—The term ''medical device'' has the meaning given such term in section

201(h) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(h)).

(15) NON-ECONOMIC DAMAGES.—The term ''non-economic damages'' means damages paid to an individual for pain and suffering, inconvenience, emotional distress, mental anguish, loss of consortium, injury to reputation, humiliation, and other nonpecuniary losses.

(16) PERSON.—The term ''person'' means any individual, corporation, company, association, firm, partnership, society, joint stock company, or any other entity, including any governmental entity.

(17) PRODUCT SELLER.—

(A) IN GENERAL.—Subject to subparagraph (B), the term ''product seller'' means a person who, in the course of a business conducted for that purpose—

(i) sells, distributes, rents, leases, prepares, blends, packages, labels, or is otherwise involved in placing, a product in the stream of commerce, or

(ii) installs, repairs, or maintains the harm-causing aspect of a product.

(B) EXCLUSION.—Such term does not include—

(i) a seller or lessor of real property;

(ii) a provider of professional services in any case in which the sale or use of a product is incidental to the transaction and the essence of the transaction is the furnishing of judgment, skill, or services; or

(iii) any person who—

(I) acts in only a financial capacity with respect to the sale of a product; or

(II) leases a product under a lease arrangement in which the selection, possession, maintenance, and operation of the product are controlled by a person other than the lessor.

(18) PUNITIVE DAMAGES.—The term ''punitive damages'' means damages awarded against any person not to compensate for actual injury suffered, but to punish or deter such person or others from engaging in similar behavior in the future.

(19) STATE.—The term ''State'' means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, and any other territory or possession of the United States.

SEC. 4003. EFFECTIVE DATE.

This title will apply to—

(1) any health care liability action brought in a Federal or State court, and

(2) any health care liability claim subject to an alternative dispute resolution system,

that is initiated on or after the date of enactment of this title, except that any health care liability claim or action arising from an injury occurring before the date of enactment of this title shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

Subtitle B—Uniform Standards for Health Care Liability Actions

SEC. 4011. STATUTE OF LIMITATIONS.

A health care liability action may not be brought after the expiration of the 2-year period that begins on the date on which the alleged injury that is the subject of the action was discovered or should reasonably have been discovered, but in no case after the expiration of the 5-year period that begins on the date the alleged injury occurred.

SEC. 4012. CALCULATION AND PAYMENT OF DAMAGES.

(a) TREATMENT OF NON-ECONOMIC DAMAGES.—

(1) LIMITATION ON NON-ECONOMIC DAMAGES.—The total amount of non-economic damages

that may be awarded to a claimant for losses resulting from the injury which is the subject of a health care liability action may not exceed $250,000, regardless of the number of parties against whom the action is brought or the number of actions brought with respect to the injury. The limitation under this paragraph shall not apply to an action for damages based solely on intentional denial of medical treatment necessary to preserve a patient's life that the patient is otherwise qualified to receive, against the wishes of a patient, or if the patient is incompetent, against the wishes of the patient's guardian, on the basis of the patient's present or predicated age, disability, degree of medical dependency, or quality of life.

(2) LIMIT.—If, after the date of the enactment of this Act, a State enacts a law which prescribes the amount of non-economic damages which may be awarded in a health care liability action which is different from the amount prescribed by section 4012(a)(1), the State amount shall apply in lieu of the amount prescribed by such section. If, after the date of the enactment of this Act, a State enacts a law which limits the amount of recovery in a health care liability action without delineating between eco-

nomic and non-economic damages, the State amount shall apply in lieu of the amount prescribed by such section.

(3) JOINT AND SEVERAL LIABILITY.—In any health care liability action brought in State or Federal court, a defendant shall be liable only for the amount of non-economic damages attributable to such defendant in direct proportion to such defendant's share of fault or responsibility for the claimant's actual damages, as determined by the trier of fact. In all such cases, the liability of a defendant for non-economic damages shall be several and not joint and a separate judgment shall be rendered against each defendant for the amount allocated to such defendant.

(b) TREATMENT OF PUNITIVE DAMAGES.—

(1) GENERAL RULE.—Punitive damages may, to the extent permitted by applicable State law, be awarded in any health care liability action for harm in any Federal or State court against a defendant if the claimant establishes by clear and convincing evidence that the harm suffered was the result of conduct—

(A) specifically intended to cause harm, or

(B) conduct manifesting a conscious, flagrant indifference to the rights or safety of others.

(2) APPLICABILITY.—This subsection shall apply to any health care liability action brought in any Federal or State court on any theory where punitive damages are sought. This subsection does not create a cause of action for punitive damages. This subsection does not preempt or supersede any State or Federal law to the extent that such law would further limit the award of punitive damages.

(3) BIFURCATION.—At the request of any party, the trier of fact shall consider in a separate proceeding whether punitive damages are to be awarded and the amount of such award. If a separate proceeding is requested, evidence relevant only to the claim of punitive damages, as determined by applicable State law, shall be inadmissible in any proceeding to determine whether actual damages are to be awarded.

(4) DRUGS AND DEVICES.—

(A) IN GENERAL.—

(i) PUNITIVE DAMAGES.—Punitive damages shall not be awarded against a manufacturer or product seller of a drug

or medical device which caused the claimant's harm where—

(I) such drug or device was subject to premarket approval by the Food and Drug Administration with respect to the safety of the formulation or performance of the aspect of such drug or device which caused the claimant's harm, or the adequacy of the packaging or labeling of such drug or device which caused the harm, and such drug, device, packaging, or labeling was approved by the Food and Drug Administration; or

(II) the drug is generally recognized as safe and effective pursuant to conditions established by the Food and Drug Administration and applicable regulations, including packaging and labeling regulations.

(ii) APPLICATION.—Clause (i) shall not apply in any case in which the defendant, before or after premarket approval of a drug or device—

(I) intentionally and wrongfully withheld from or misrepresented to the Food and Drug Administration information concerning such drug or device required to be submitted under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.) or section 351 of the Public Health Service Act (42 U.S.C. 262) that is material and relevant to the harm suffered by the claimant, or

(II) made an illegal payment to an official or employee of the Food and Drug Administration for the purpose of securing or maintaining approval of such drug or device.

(B) PACKAGING.—In a health care liability action for harm which is alleged to relate to the adequacy of the packaging or labeling of a drug which is required to have tamper-resistant packaging under regulations of the Secretary of Health and Human Services (including labeling regulations related to such packaging), the manufacturer or product seller of the drug shall not be held liable for punitive damages unless

such packaging or labeling is found by the court by clear and convincing evidence to be substantially out of compliance with such regulations.

(c) PERIODIC PAYMENTS FOR FUTURE LOSSES.—

(1) GENERAL RULE.—In any health care liability action in which the damages awarded for future economic and non-economic loss exceeds $50,000, a person shall not be required to pay such damages in a single, lump-sum payment, but shall be permitted to make such payments periodically based on when the damages are likely to occur, as such payments are determined by the court.

(2) FINALITY OF JUDGMENT.—The judgment of the court awarding periodic payments under this subsection may not, in the absence of fraud, be reopened at any time to contest, amend, or modify the schedule or amount of the payments.

(3) LUMP-SUM SETTLEMENTS.—This subsection shall not be construed to preclude a settlement providing for a single, lump-sum payment.

(d) TREATMENT OF COLLATERAL SOURCE PAYMENTS.—

(1) INTRODUCTION INTO EVIDENCE.—In any health care liability action, any defendant may introduce evidence of collateral source payments. If any

defendant elects to introduce such evidence, the claimant may introduce evidence of any amount paid or contributed or reasonably likely to be paid or contributed in the future by or on behalf of the claimant to secure the right to such collateral source payments.

(2) NO SUBROGATION.—No provider of collateral source payments shall recover any amount against the claimant or receive any lien or credit against the claimant's recovery or be equitably or legally subrogated to the right of the claimant in a health care liability action.

(3) APPLICATION TO SETTLEMENTS.—This subsection shall apply to an action that is settled as well as an action that is resolved by a fact finder.

SEC. 4013. ALTERNATIVE DISPUTE RESOLUTION.

Any ADR used to resolve a health care liability action or claim shall contain provisions relating to statute of limitations, non-economic damages, joint and several liability, punitive damages, collateral source rule, and periodic payments which are consistent with the provisions relating to such matters in this title.

TITLE V—CONFIDENTIALITY OF HEALTH INFORMATION

SEC. 5001. CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION.

(a) IN GENERAL.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by adding at the end the following:

''PART D—CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION

''INSPECTION AND COPYING OF PROTECTED HEALTH INFORMATION

''SEC. 1181. (a) IN GENERAL.—Subject to the succeeding provisions of this section, upon the request of an individual who is the subject of protected health information, a person who is a health care provider, health plan, employer, health or life insurer, or educational institution shall make available to the individual (or, in the discretion of the person, to a health care provider designated by the individual), for inspection and copying, protected health information concerning the individual that the person maintains, including records created under section 1182.

''(b) ACCESS THROUGH ORIGINATING PROVIDER.—Protected health information that is created by an originating provider, and subsequently received by another health care provider or a health plan as part of treatment

or payment activities, shall be made available for inspection and copying as provided in this section through the originating provider, rather than the receiving health care provider or health plan, unless the originating provider does not maintain the information.

''(c) INVESTIGATIONAL INFORMATION.—With respect to protected health information that was created as part of the requesting individual's participation in a clinical trial monitored by an institutional review board established to review health research with respect to potential risks to human subjects pursuant to Federal regulations adopted under section 1802(b) of the Public Health Service Act (42 U.S.C. 300v–1(b)) and the notice (informally referred to as the 'Common Rule') promulgated in the Federal Register at 56 Fed. Reg. 28003), a request under subsection (a) shall be granted only to the extent and in a manner consistent with such regulations.

''(d) OTHER EXCEPTIONS.—Unless ordered by a court of competent jurisdiction, a person to whom a request under subsection (a) is made is not required to grant the request, if—

''(1) the person determines that the disclosure of the information could reasonably be expected to endanger the life or physical safety of, or cause substantial harm to, any individual; or

''(2) the information is compiled principally—

''(A) in anticipation of a civil, criminal, or administrative action or proceeding; or

''(B) for use in such action or proceeding.

''(e) DENIAL OF REQUEST FOR INSPECTION OR COPYING.—If a person to whom a request under subsection (a) is made denies a request for inspection or copying pursuant to this section, the person shall inform the individual making the request, in writing, of—

''(1) the reasons for the denial of the request;

''(2) the availability of procedures for further review of the denial; and

''(3) the individual's right to file with the person a concise statement setting forth the request.

''(f) STATEMENT REGARDING REQUEST.—If an individual has filed with a person a statement under subsection (e)(3) with respect to protected health information, the person, in any subsequent disclosure of the information—

''(1) shall include a notation concerning the individual's statement; and

''(2) may include a concise statement of the reasons for denying the request for inspection or copying.

''(g) PROCEDURES.—A person providing access to protected health information for inspection or copying under this section may set forth appropriate procedures to be followed for such inspection or copying and may require an individual to pay reasonable costs associated with such inspection or copying.

''(h) INSPECTION AND COPYING OF SEGREGABLE PORTION.—A person to whom a request under subsection (a) is made shall permit the inspection and copying of any reasonably segregable portion of a record after deletion of any portion that the person is not required to disclose under this section.

''(i) DEADLINE.—A person described in subsection (a) shall comply with or deny, in accordance with this section, a request for inspection or copying of protected health information under this section not later than 30 days after the date on which the person receives the request.

''(j) RULES GOVERNING AGENTS.—An agent of a person described in subsection (a) shall not be required to provide for the inspection and copying of protected health information, except where—

''(1) the protected health information is retained by the agent; and

''(2) the agent has been asked by the person to fulfill the requirements of this section.

''SUPPLEMENTATION OF PROTECTED HEALTH INFORMATION

''SEC. 1182. (a) IN GENERAL.—Subject to subsection (b), not later than 45 days after the date on which a person who is a health care provider, health plan, employer, health or life insurer, or educational institution receives, from an individual who is a subject of protected health information that is maintained by the person, a request in writing to amend the information by adding a concise written supplement to it, the person—

''(1) shall make the amendment requested;

''(2) shall inform the individual of the amendment that has been made; and

''(3) shall make reasonable efforts to inform any person who is identified by the individual, who is not an officer, employer, or agent of the person receiving the request, and to whom the unamended portion of the information was disclosed during the preceding year, by sending a notice to the person's last known address that an amendment, consisting of the addition of a supplement, has been made to the protected health information of the individual.

''(b) REFUSAL TO AMEND.—If a person described in subsection (a) refuses to make an amendment requested

by an individual under such subsection, the person shall inform the individual, in writing, of—

"(1) the reasons for the refusal to make the amendment;

"(2) any procedures for further review of the refusal; and

"(3) the individual's right to file with the person a concise statement setting forth the requested amendment and the individual's reasons for disagreeing with the refusal.

"(c) STATEMENT OF DISAGREEMENT.—If an individual has filed a statement of disagreement with a person under subsection (b)(3), the person, in any subsequent disclosure of the disputed portion of the information—

"(1) shall include a notation that such individual has filed a statement of disagreement; and

"(2) may include a concise statement of the reasons for not making the requested amendment.

"(d) RULES GOVERNING AGENTS.—The agent of a person described in subsection (a) shall not be required to make amendments to individually identifiable health information, except where—

"(1) the information is retained by the agent; and

''(2) the agent has been asked by such person to fulfill the requirements of this section.

''(e) DUPLICATIVE REQUESTS FOR AMENDMENTS.—If a person described in subsection (a) receives a duplicative request for an amendment of information as provided for in such subsection and a statement of disagreement with respect to the request has been filed pursuant to subsection (c), the person shall inform the individual of such filing and shall not be required to carry out the procedures under this section.

''(f) RULE OF CONSTRUCTION.—This section shall not be construed—

''(1) to permit an individual to modify statements in his or her record that document the factual observations of another individual or state the results of diagnostic tests; or

''(2) to permit an individual to amend his or her record as to the type, duration, or quality of treatment the individual believes he or she should have been provided.

''NOTICE OF CONFIDENTIALITY PRACTICES

''SEC. 1183. (a) PREPARATION OF WRITTEN NOTICE.—A person who is a health care provider, health plan, health oversight agency, public health authority, employer, health or life insurer, health researcher, or educational institution shall post or provide, in writing and

in a clear and conspicuous manner, notice of the person's protected health information confidentiality practices. The notice shall include—

''(1) a description of an individual's rights with respect to protected health information;

''(2) the intended uses and disclosures of protected health information;

''(3) the procedures established by the person for the exercise of an individual's rights with respect to protected health information; and

''(4) the procedures established by the person for obtaining copies of the notice.

''(b) MODEL NOTICE.—The Secretary, after notice and opportunity for public comment, and based on the advice of the National Committee on Vital and Health Statistics established under section 306(k) of the Public Health Service Act (42 U.S.C. 242k(k)), shall develop and disseminate, not later than 6 months after the date of the enactment of the Patient Protection Act of 1998, model notices of confidentiality practices, for use under this section. Use of a model notice developed by the Secretary shall serve as a complete defense in any civil action to an allegation that a violation of this section has occurred.

''ESTABLISHMENT OF SAFEGUARDS

''SEC. 1184. (a) IN GENERAL.—A person who is a health care provider, health plan, health oversight agency,

public health authority, employer, health or life insurer, health researcher, or educational institution shall establish, maintain, and enforce reasonable and appropriate administrative, technical, and physical safeguards to protect the confidentiality, security, accuracy, and integrity of protected health information created, received, obtained, maintained, used, transmitted, or disposed of by the person.

''(b) FACTORS TO BE CONSIDERED.—A person subject to subsection (a) shall consider the following factors in establishing safeguards under such subsection:

''(1) The need for protected health information.

''(2) The categories of personnel who will have access to protected health information.

''(3) The feasibility of limiting access to individual identifiers.

''(4) The appropriateness of the policy or procedure to the person, and to the medium in which protected health information is stored and transmitted.

''(5) The value of audit trails in computerized records.

''(c) RELATIONSHIP TO PART C REQUIREMENT.—Any safeguard established under this section shall be consistent with the requirement in section 1173(d)(2).

''(d) CONVERSION TO NONIDENTIFIABLE HEALTH INFORMATION.—A person subject to subsection (a) shall, to the extent practicable and consistent with the purpose for which protected health information is maintained, convert such information into nonidentifiable health information.

''AVAILABILITY OF PROTECTED HEALTH INFORMATION FOR PURPOSES OF HEALTH CARE OPERATIONS

''SEC. 1185. DISCLOSURE.—Any person who maintains protected health information may disclose the information to a health care provider or a health plan for the purpose of permitting the provider or plan to conduct health care operations.

''(b) USE.—A health care provider or a health plan that maintains protected health information may use it for the purposes described in subsection (a).

''RELATIONSHIP TO OTHER LAWS

''SEC. 1186. (a) STATE LAW.—

''(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), the provisions of this part shall preempt a provision of State law to the extent that such provision—

''(A) otherwise would be preempted as inconsistent with this part under article VI of the Constitution of the United States;

''(B) relates to authorization for the use or disclosure of—

''(i) protected health information for health care operations; or

''(ii) nonidentifiable health information; or

''(C) relates to any of the following:

''(i) Inspection or copying of protected health information by a person who is a subject of the information.

''(ii) Amendment of protected health information by a person who is a subject of the information.

''(iii) Notice of confidentiality practices with respect to protected health information.

''(iv) Establishment of safeguards for protected health information.

''(2) EXCEPTIONS.—Nothing in this part shall be construed to preempt or modify a provision of State law to the extent that such provision relates to protected health information and—

''(A) the confidentiality of the records maintained by a licensed mental health professional;

"(B) the provision of health care to a minor, or the disclosure of information about a minor to a parent or guardian of the minor;

"(C) condition-specific limitations on disclosure;

"(D) the use or disclosure of information for use in legally authorized—

"(i) disease or injury reporting;

"(ii) public health surveillance, investigation, or intervention;

"(iii) vital statistics reporting, such as reporting of birth or death information;

"(iv) reporting of abuse or neglect information;

"(v) reporting of information concerning a communicable disease status; or

"(vi) reporting concerning the safety or effectiveness of a biological product regulated under section 351 of the Public Health Service Act (42 U.S.C. 262) or a drug or device regulated under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.);

"(E) the disclosure to a person by a health care provider of information about an individ-

ual, in any case in which the provider has determined—

"(i) in the provider's reasonable medical judgment, that the individual is unconscious, incompetent, or otherwise incapable of deciding whether to authorize disclosure of the protected health information; and

"(ii) in the provider's reasonable judgment, that the person is a spouse, relative, guardian, or close friend of the individual's; or

"(F) the use of information by, or the disclosure of information to, a person holding a valid and applicable power of attorney that includes the authority to make health care decisions on behalf of an individual who is a subject of the information.

"(3) PRIVILEGES.—Nothing in this part shall be construed to preempt or modify a provision of State law to the extent that such provision relates to a privilege of a witness or other person in a court of that State.

"(b) FEDERAL LAW.—Nothing in this part shall be construed to preempt, modify, or repeal a provision of any other Federal law relating to protected health information

or relating to an individual's access to protected health information or health care services. Nothing in this part shall be construed to preempt, modify, or repeal a provision of Federal law to the extent that such provision relates to a privilege of a witness or other person in a court of the United States.

''CIVIL PENALTIES

''SEC. 1187. (a) VIOLATION.—A person who the Secretary determines has substantially and materially failed to comply with this part shall be subject, in addition to any other penalties that may be prescribed by law—

''(1) in a case in which the violation relates to section 1181 or 1182, to a civil penalty of not more than $500 for each such violation but not to exceed $5,000 in the aggregate for all violations of an identical requirement or prohibition during a calendar year;

''(2) in the case in which the violation relates to section 1183 or 1184, to a civil penalty of not more than $10,000 for each such violation, but not to exceed $50,000 in the aggregate for all violations of an identical requirement or prohibition during a calendar year; or

''(3) in a case in which the Secretary finds that such violations have occurred with such frequency as

to constitute a general business practice, to a civil penalty of not more than $100,000.

''(b) PROCEDURES FOR IMPOSITION OF PENALTIES.—Section 1128A, other than subsections (a) and (b) and the second sentence of subsection (f) of that section, shall apply to the imposition of a civil or monetary penalty under this section in the same manner as such provisions apply with respect to the imposition of a penalty under section 1128A.

''DEFINITIONS

''SEC. 1188. As used in this part:

''(1) AGENT.—The term 'agent' means a person, including a contractor, who represents and acts for another under the contract or relation of agency, or whose function is to bring about, modify, affect, accept performance of, or terminate contractual obligations between the principal and a third person.

''(2) CONDITION-SPECIFIC LIMITATIONS ON DISCLOSURE.—The term 'condition-specific limitations on disclosure' means State laws that prohibit the disclosure of protected health information relating to a health condition or disease that has been identified by the Secretary as posing a public health threat.

''(3) DISCLOSE.—The term 'disclose' means to release, transfer, provide access to, or otherwise divulge protected health information to any person

other than an individual who is the subject of such information.

''(4) EDUCATIONAL INSTITUTION.—The term 'educational institution' means an institution or place accredited or licensed for purposes of providing for instruction or education, including an elementary school, secondary school, or institution of higher learning, a college, or an assemblage of colleges united under one corporate organization or government.

''(5) EMPLOYER.—The term 'employer' has the meaning given such term under section 3(5) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(5)), except that such term shall include only employers of two or more employees.

''(6) HEALTH CARE.—The term 'health care' means—

''(A) preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, including appropriate assistance with disease or symptom management and maintenance, counseling, service, or procedure—

''(i) with respect to the physical or mental condition of an individual; or

''(ii) affecting the structure or function of the human body or any part of the human body, including the banking of blood, sperm, organs, or any other tissue; or

''(B) any sale or dispensing, pursuant to a prescription or medical order, of a drug, device, equipment, or other health care-related item to an individual, or for the use of an individual.

''(7) HEALTH CARE OPERATIONS.—The term 'health care operations' means services, provided directly by or on behalf of a health plan or health care provider or by its agent, for any of the following purposes:

''(A) Coordinating health care, including health care management of the individual through risk assessment, case management, and disease management.

''(B) Conducting quality assessment and improvement activities, including outcomes evaluation, clinical guideline development and improvement, and health promotion.

''(C) Carrying out utilization review activities, including precertification and preauthorization of services, and health plan

rating activities, including underwriting and experience rating.

''(D) Conducting or arranging for auditing services.

''(8) HEALTH CARE PROVIDER.—The term 'health care provider' means a person, who with respect to a specific item of protected health information, receives, creates, uses, maintains, or discloses the information while acting in whole or in part in the capacity of—

''(A) a person who is licensed, certified, registered, or otherwise authorized by Federal or State law to provide an item or service that constitutes health care in the ordinary course of business, or practice of a profession;

''(B) a Federal, State, or employer-sponsored or any other privately-sponsored program that directly provides items or services that constitute health care to beneficiaries; or

''(C) an officer or employee of a person described in subparagraph (A) or (B).

''(9) HEALTH OR LIFE INSURER.—The term 'health or life insurer' means a health insurance issuer, as defined in section 9832(b)(2) of the Inter-

nal Revenue Code of 1986, or a life insurance company, as defined in section 816 of such Code.

''(10) HEALTH PLAN.—The term 'health plan' means any health insurance plan, including any hospital or medical service plan, dental or other health service plan, health maintenance organization plan, plan offered by a provider-sponsored organization (as defined in section 1855(d)), or other program providing or arranging for the provision of health benefits.

''(11) HEALTH RESEARCHER.—The term 'health researcher' means a person (or an officer, employee, or agent of a person) who is engaged in systematic investigation, including research development, testing, data analysis, and evaluation, designed to develop or contribute to generalizable knowledge relating to basic biomedical processes, health, health care, health care delivery, or health care cost.

''(12) NONIDENTIFIABLE HEALTH INFORMATION.—The term 'nonidentifiable health information' means protected health information from which personal identifiers that reveal the identity of the individual who is the subject of such information or provide a direct means of identifying the individual

(such as name, address, and social security number) have been removed, encrypted, or replaced with a code, such that the identity of the individual is not evident without (in the case of encrypted or coded information) use of a key.

''(13) ORIGINATING PROVIDER.—The term 'originating provider', when used with respect to protected health information, means the health care provider who takes an action that initiates the treatment episode to which that information relates, such as prescribing a drug, ordering a diagnostic test, or admitting an individual to a health care facility. A hospital or nursing facility is the originating provider with respect to protected health information created or received as part of inpatient or outpatient treatment provided in the hospital or facility.

''(14) PAYMENT ACTIVITIES.—The term 'payment activities' means—

''(A) activities undertaken—

''(i) by, or on behalf of, a health plan to determine its responsibility for coverage under the plan; or

''(ii) by a health care provider to obtain payment for items or services provided to an individual, provided under a health

plan, or provided based on a determination by the health plan of responsibility for coverage under the plan; and

''(B) includes the following activities, when performed in a manner consistent with subparagraph (A):

''(i) Billing, claims management, medical data processing, other administrative services, and actual payment.

''(ii) Determinations of coverage or adjudication of health benefit or subrogation claims.

''(iii) Review of health care services with respect to coverage under a health plan or justification of charges.

''(15) PERSON.—The term 'person' means—

''(A) a natural person;

''(B) a government or governmental subdivision, agency, or authority;

''(C) a company, corporation, estate, firm, trust, partnership, association, joint venture, society, or joint stock company; or

''(D) any other legal entity.

''(16) PROTECTED HEALTH INFORMATION.—The term 'protected health information', when used

with respect to an individual who is a subject of information means any information (including genetic information) that identifies the individual, whether oral or recorded in any form or medium, and that—

''(A) is created or received by a health care provider, health plan, health oversight agency, public health authority, employer, health or life insurer, or educational institution;

''(B) relates to the past, present, or future physical or mental health or condition of an individual (including individual cells and their components);

''(C) is derived from—

''(i) the provision of health care to an individual; or

''(ii) payment for the provision of health care to an individual; and

''(D) is not nonidentifiable health information.

''(17) STATE.—The term 'State' includes the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

''(18) TREATMENT.—The term 'treatment' means the provision of health care by a health care provider.

''(19) WRITING.—The term 'writing' means writing either in a paper-based, computer-based, or electronic form, including electronic signatures.''.

(b) ENFORCEMENT OF PROVISIONS THROUGH CONDITIONS ON PARTICIPATION.—

(1) PARTICIPATING PHYSICIANS AND SUPPLIERS.—Section 1842(h) of the Social Security Act (42 U.S.C. 1395u(h)) is amended by adding at the end the following:

''(9) The Secretary may refuse to enter into an agreement with a physician or supplier under this subsection, or may terminate or refuse to renew such agreement, in the event that such physician or supplier has been found to have violated a provision of part D of title XI.''.

(2) MEDICARE+CHOICE ORGANIZATIONS.—Section 1852(h) of the Social Security Act (42 U.S.C. 1395w–22(h)) is amended—

(A) in the matter preceding paragraph (1), by striking ''procedures—'' and inserting ''procedures, consistent with sections 1181 through 1185—''; and

(B) in paragraph (1), by striking ''privacy of any individually identifiable enrollee information;'' and inserting ''confidentiality of protected health information concerning enrollees;''.

(3) MEDICARE PROVIDERS.—Section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1)) is amended—

(A) by inserting a semicolon at the end of subparagraph (R);

(B) by striking the period at the end of subparagraph (S) and inserting ''; and''; and

(C) by inserting immediately after subparagraph (S) the following new subparagraph:

''(T) to comply with sections 1181 through 1184.''.

(4) HEALTH MAINTENANCE ORGANIZATIONS WITH RISK-SHARING CONTRACTS.—Section 1876(k)(4) of the Social Security Act (42 U.S.C. 1395mm(k)(4)) of the Social Security Act is amended by adding at the end the following:

''(E) The confidentiality and accuracy procedure requirements under section 1852(h).''.

(c) CONFORMING AMENDMENTS.—

(1) TITLE HEADING.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by striking the title heading and inserting the following: ''TITLE XI—GENERAL PROVISIONS, PEER REVIEW, ADMINISTRATIVE SIMPLIFICATION, AND CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION''.

(2) NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS.—Section 306(k)(5) of the Public Health Service Act (42 U.S.C. 242(k)(5)) is amended—

(A) in subparagraphs (A)(viii) and (D), by striking ''part C'' and inserting ''parts C and D'';

(B) in subparagraph (C), by striking ''and'' at the end;

(C) in subparagraph (D), by striking the period at the end and inserting ''; and''; and

(D) by adding at the end the following:

''(E) shall study the issues relating to section 1184 of the Social Security Act (as added by the Patient Protection Act of 1998), and, not later than 1 year after the date of the enactment of the Patient Protection Act of 1998, shall report to the Congress on such section.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date that is 1 year after the date of the enactment of this Act, except that subsection (c)(2), and section 1183(b) of the Social Security Act (as added by subsection (a)), shall take effect on the date of the enactment of this Act.

SEC. 5002. STUDY AND REPORT ON EFFECT OF STATE LAW ON HEALTH-RELATED RESEARCH.

Not later than one year after the date of the enactment of this Act, the Comptroller General of the United States shall prepare and submit to the Congress a report containing the results of a study on the effect of State laws on health-related research subject to review by an institutional review board or institutional review committee with respect to the protection of human subjects.

SEC. 5003. STUDY AND REPORT ON STATE LAW ON PROTECTED HEALTH INFORMATION.

(a) IN GENERAL.—Not later than 9 months after the date of the enactment of this Act, the Comptroller General of the United States shall prepare and submit to the Congress a report containing the results of a study—

(1) compiling State laws on the confidentiality of protected health information (as defined in section 1188 of the Social Security Act, as added by section 5001 of this Act); and

(2) analyzing the effect of such laws on the provision of health care and securing payment for such care.

(b) MODIFICATION OF DEADLINE.—Section 264(c)(1) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 2033) is amended by striking ''36 months after the date of the enactment of this Act,'' and inserting ''6 months after the date on which the Comptroller General of the United States submits to the Congress a report under section 5003(a) of the Patient Protection Act of 1998,''.

SEC. 5004. PROTECTION FOR CERTAIN INFORMATION DEVELOPED TO REDUCE MORTALITY OR MORBIDITY OR FOR IMPROVING PATIENT CARE AND SAFETY.

(a) PROTECTION OF CERTAIN INFORMATION.—Notwithstanding any other provision of Federal or State law, health care response information shall be exempt from any disclosure requirement (regardless of whether the requirement relates to subpoenas, discovery, introduction of evidence, testimony, or any other form of disclosure), in connection with a civil or administrative proceeding under Federal or State law, to the same extent as information developed by a health care provider with respect to any of the following:

(1) Peer review.

(2) Utilization review.

(3) Quality management or improvement.

(4) Quality control.

(5) Risk management.

(6) Internal review for purposes of reducing mortality, morbidity, or for improving patient care or safety.

(b) NO WAIVER OF PROTECTION THROUGH INTERACTION WITH ACCREDITING BODY.—Notwithstanding any other provision of Federal or State law, the protection of health care response information from disclosure provided under subsection (a) shall not be deemed to be modified or in any way waived by—

(1) the development of such information in connection with a request or requirement of an accrediting body; or

(2) the transfer of such information to an accrediting body.

(c) DEFINITIONS.—For purposes of this section:

(1) The term ''accrediting body'' means a national, not-for-profit organization that—

(A) accredits health care providers; and

(B) is recognized as an accrediting body by statute or by a Federal or State agency that regulates health care providers.

(2) The term ''health care provider'' has the meaning given such term in section 1188 of the Social Security Act (as added by section 5001 of this Act).

(3) The term ''health care response information'' means information (including any data, report, record, memorandum, analysis, statement, or other communication) developed by, or on behalf of, a health care provider in response to a serious, adverse, patient-related event—

(A) during the course of analyzing or studying the event and its causes; and

(B) for purposes of—

(i) reducing mortality or morbidity; or

(ii) improving patient care or safety (including the provider's notification to an accrediting body and the provider's plans of action in response to such event).

(5) The term ''State'' has the meaning given such term in section 1188 of the Social Security Act (as added by section 5001 of this Act).

TITLE VI—MEDICAL SAVINGS ACCOUNTS FOR FEDERAL EMPLOYEES

SEC. 6001. MEDICAL SAVINGS ACCOUNTS FOR FEDERAL EMPLOYEES.

(a) MEDICAL SAVINGS ACCOUNTS.—

(1) CONTRIBUTIONS.—Title 5, United States Code, is amended by redesignating section 8906a as section 8906c and by inserting after section 8906 the following:

"§ 8906a. Government contributions to medical savings accounts

''(a) An employee or annuitant enrolled in a high deductible health plan is entitled, in addition to the Government contribution under section 8906(b) toward the subscription charge for such plan, to have a Government contribution made, in accordance with succeeding provisions of this section, to a medical savings account of such employee or annuitant.

''(b)(1) The biweekly Government contribution under this section shall, in the case of any such employee or annuitant, be equal to the amount by which—

''(A) the biweekly equivalent of the maximum Government contribution for the contract year in-

volved (as defined by paragraph (2)), exceeds (if at all)

"(B) the amount of the biweekly Government contribution payable on such employee's or annuitant's behalf under section 8906(b) for the period involved.

"(2) For purposes of this section, the term 'maximum Government contribution' means, with respect to a contract year, the maximum Government contribution that could be made for health benefits for an employee or annuitant for such contract year, as determined under section 8906(b) (disregarding paragraph (2) thereof)).

"(3) Notwithstanding any other provision of this section, no contribution under this section shall be payable to any medical savings account of an employee or annuitant for any period—

"(A) if, as of the first day of the month before the month in which such period commences, such employee or annuitant (or the spouse of such employee or annuitant, if coverage is for self and family) is entitled to benefits under part A of title XVIII of the Social Security Act;

"(B) to the extent that such contribution, when added to previous contributions made under this section for that same year with respect to such em-

ployee or annuitant, would cause the total to exceed—

"(i) the highest annual limit deductible permitted under clause (i) or (ii) of section 220(c)(2)(A) of the Internal Revenue Code of 1986, as appropriate (determined taking into account any changes in coverage that may occur), for the calendar year in which such period commences; or

"(ii) such lower amount (relative to the limitation that would otherwise apply under clause (i)) as the employee or annuitant may specify in accordance with regulations of the Office, including an election not to receive contributions under this section for a year or the remainder of a year; or

"(C) for which any information (or documentation) under subsection (d) that is needed in order to make such contribution has not been timely submitted.

"(4) Notwithstanding any other provision of this section, no contribution under this section shall be payable to any medical savings account of an employee for any period in a contract year unless that employee was en-

rolled in a health benefits plan under this chapter as an employee for not less than—

''(A) the 1 year of service immediately before the start of such contract year, or

''(B) the full period or periods of service between the last day of the first period, as prescribed by regulations of the Office of Personnel Management, in which he is eligible to enroll in the plan and the day before the start of such contract year,

whichever is shorter.

''(5) The Office shall provide for the conversion of biweekly rates of contributions specified by paragraph (1) to rates for employees and annuitants whose pay or annuity is provided on other than a biweekly basis, and for this purpose may provide for the adjustment of the converted rate to the nearest cent.

''(c) A Government contribution under this section—

''(1) shall be made at the same time that, and the same frequency with which, Government contributions under section 8906(b) are made for the benefit of the employee or annuitant involved; and

''(2) shall be payable from the same appropriation, fund, account, or other source as would any Government contributions under section 8906(b) with respect to the employee or annuitant involved.

''(d) The Office shall by regulation prescribe the time, form, and manner in which an employee or annuitant shall submit any information (and supporting documentation) necessary to identify any medical savings account to which contributions under this section are requested to be made.

''(e) Nothing in this section shall be considered to entitle an employee or annuitant to any Government contribution under this section with respect to any period for which such employee or annuitant is ineligible for a Government contribution under section 8906(b).

''§ 8906b. Individual contributions to medical savings accounts

''(a) Upon the written request of an employee or annuitant enrolled in a high deductible health plan, there shall be withheld from the pay or annuity of such employee or annuitant and contributed to the medical savings account identified by such employee or annuitant in accordance with applicable regulations under subsection (c) such amount as the employee or annuitant may specify.

''(b) Notwithstanding subsection (a), no withholding under this section may be made from the pay or annuity of an employee or annuitant for any period—

''(1) if, or to the extent that, a Government contribution for such period under section 8906a

would not be allowable by reason of subparagraph (A) or (B)(i) of subsection (b)(3) thereof;

''(2) for which any information (or documentation) that is needed in order to make such contribution has not been timely submitted; or

''(3) if the employee or annuitant submits a request for termination of withholdings, beginning on or after the effective date of the request and before the end of the year.

''(c) The Office of Personnel Management shall prescribe any regulations necessary to carry out this section, including provisions relating to the time, form, and manner in which any request for withholdings under this section may be made, changed, or terminated.''.

(2) RULES OF CONSTRUCTION.—Nothing in this section or in any amendment made by this section shall be considered—

(A) to permit or require that any contributions to a medical savings account (whether by the Government or through withholdings from pay or annuity) be paid into the Employees Health Benefits Fund; or

(B) to affect any authority under section 1005(f) of title 39, United States Code, to vary, add to, or substitute for any provision of chap-

ter 89 of title 5, United States Code, as amended by this section.

(3) CONFORMING AMENDMENTS.—

(A) The table of sections at the beginning of chapter 89 of title 5, United States Code, is amended by striking the item relating to section 8906a and inserting the following:

''8906a. Government contributions to medical savings accounts.
''8906b. Individual contributions to medical savings accounts.
''8906c. Temporary employees.''.

(B) Section 8913(b)(4) of title 5, United States Code, is amended by striking ''8906a(a)'' and inserting ''8906c(a)''.

(b) INFORMATIONAL REQUIREMENTS.—Section 8907 of title 5, United States Code, is amended by adding at the end the following:

''(c) In addition to any information otherwise required under this section, the Office shall make available to all employees and annuitants eligible to enroll in a high deductible health plan, information relating to—

''(1) the conditions under which Government contributions under section 8906a shall be made to a medical savings account;

''(2) the amount of any Government contributions under section 8906a to which an employee or annuitant may be entitled (or how such amount may be ascertained);

''(3) the conditions under which contributions to a medical savings account may be made under section 8906b through withholdings from pay or annuity; and

''(4) any other matter the Office considers appropriate in connection with medical savings accounts.''.

(c) HIGH DEDUCTIBLE HEALTH PLAN AND MEDICAL SAVINGS ACCOUNT DEFINED.—Section 8901 of title 5, United States Code, is amended—

(1) in paragraph (10) by striking ''and'' after the semicolon;

(2) in paragraph (11) by striking the period and inserting a semicolon; and

(3) by adding at the end the following:

''(12) the term 'high deductible health plan' means a plan described by section 8903(5) or section 8903a(d); and

''(13) the term 'medical savings account' has the meaning given such term by section 220(d) of the Internal Revenue Code of 1986.''.

(d) AUTHORITY TO CONTRACT FOR HIGH DEDUCTIBLE HEALTH PLANS.—Section 8902 of title 5, United States Code, is amended by adding at the end the following:

''(p)(1) The Office shall contract under this chapter for a high deductible health plan with any qualified carrier that offers such a plan and, as of the date of enactment of the Federal Employees Health Care Freedom of Choice Act, offers a health benefits plan under this chapter.

''(2) The Office may contract under this chapter for a high deductible health plan with any qualified carrier that offers such a plan, but does not, as of the date of enactment of the Federal Employees Health Care Freedom of Choice Act, offer a health benefits plan under this chapter.''.

(e) DESCRIPTION OF HIGH DEDUCTIBLE HEALTH PLANS AND BENEFITS TO BE PROVIDED THEREUNDER.—

(1) IN GENERAL.—Section 8903 of title 5, United States Code, is amended by adding at the end the following:

''(5) HIGH DEDUCTIBLE HEALTH PLANS.—(A) One or more plans described by paragraph (1), (2), (3), or (4), which—

''(i) are high deductible health plans (as defined by section 220(c)(2) of the Internal Revenue Code of 1986); and

''(ii) provide benefits of the types referred to by section 8904(a)(5).

''(B) Nothing in this section shall be considered—

''(i) to prevent a carrier from simultaneously offering a plan described by subparagraph (A) and a plan described by paragraph (1) or (2); or

''(ii) to require that a high deductible health plan offer two levels of benefits.''.

(2) TYPES OF BENEFITS.—Section 8904(a) of title 5, United States Code, is amended by inserting after paragraph (4) the following:

''(5) HIGH DEDUCTIBLE HEALTH PLANS.—Benefits of the types named under paragraph (1) or (2) of this subsection or both.''.

(3) CONFORMING AMENDMENTS.—

(A) Section 8903a of title 5, United States Code, is amended by redesignating subsection (d) as subsection (e) and by inserting after subsection (c) the following:

''(d) The plans under this section may include one or more plans, otherwise allowable under this section, that satisfy the requirements of clauses (i) and (ii) of section 8903(5)(A).''.

(B) Section 8909(d) of title 5, United States Code, is amended by striking ''8903a(d)'' and inserting ''8903a(e)''.

(4) REFERENCES.—Section 8903 of title 5, United States Code, is amended by adding after paragraph (5) (as added by paragraph (1) of this subsection) as a flush left sentence, the following:

''The Office shall prescribe regulations in accordance with which the requirements of section 8902(c), 8902(n), 8909(e), and any other provision of this chapter that applies with respect to a plan described by paragraph (1), (2), (3), or (4) of this section shall apply with respect to the corresponding plan under paragraph (5) of this section. Similar regulations shall be prescribed with respect to any plan under section 8903a(d).''.

SEC. 6002. EFFECTIVE DATE.

The amendments made by this title shall apply with respect to contract years beginning on or after January 1, 2000. The Office of Personnel Management shall take appropriate measures to ensure that coverage under a high deductible health plan under chapter 89 of title 5, United States Code (as amended by this section) shall be available as of the beginning of the first contract year described in the preceding sentence.

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